NATIONAL INSTITUTE ON
ALCOHOL ABUSE AND ALCOHOLISM

A GROWING CONCERN:

How to provide services for children from alcoholic families

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse and Mental Health Administration

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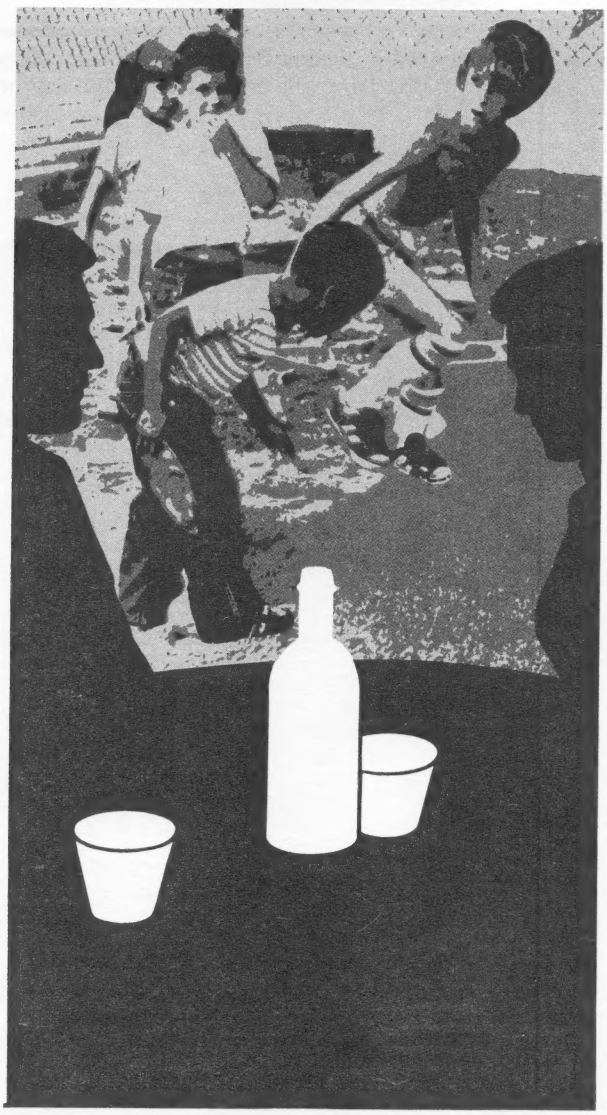

How to provide services for children from alcoholic families

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Alcohol, Drug Abuse and Mental Health Administration

5600 Fishers Lane Rockville, Maryland 20857

These materials were written by Barbara J. Waite and Meredith J. Ludwig for Evaluation Technologies Incorporated, which developed the project under contract number ADM 281-81-0009 from the National Institute on Alcohol Abuse and Alcoholism.

All characters named in the vignettes in this book are fictitious. Any resemblance to actual persons, living or dead, is purely coincidental.

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Foreword

Where children in need are concerned, even the most professional among us experience some difficulty remaining objective. But objectivity, tempered with empathy, is necessary for the teachers, counselors, law enforcement personnel, and health care professionals who must identify and assist the estimated 7 million children of alcoholics under the age of 20 in the United States.

This publication, A Growing Concern: How to Provide Services for Children from Alcoholic Families was designed to assist these professionals who must retain both their objectivity and a high level of sensitivity, due to the subtle and variable nature of the behavior manifestations seen in children from alcoholic families.

Research focused on this population is highly difficult, at best, since the stigma attached to alcoholism often causes children from alcoholic families to become remarkably adept at coping, and thereby hiding their problems from outsiders. However, persistence in research has rewarded us with the understanding we now have of these children's unique problems, and I believe that, ultimately, research will provide keys to solutions. One especially promising area involves the vulnerability factor. What enables some children to reach maturity unscathed by the alcoholism in their environment, while others, if left untreated, carry the emotional residue into adulthood?

On behalf of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), I would like to encourage professionals and volunteers who work with youth to communicate their questions and concerns on the topic of children from alcoholic families. Comments from those who work with youth can reveal special areas where research may have the most practical application. Please address all correspondence to the following:

Prevention Branch
Division of Prevention and Research Dissemination
NIAAA
Room 16C14
5600 Fishers Lane
Rockville, MD 20857

It is my hope that this publication, A Growing Concern: How to Provide Services for Children from Alcoholic Families, will become a valuable tool for caregivers whose goal is the reduction of alcoholism and the toll it takes on young lives.

Robert G. Niven, M.D.
Director
National Institute on Alcohol
Abuse and Alcoholism

Introduction

Background

Awareness of the problems and service needs of children from alcoholic families has increased significantly over the past 10 years. Clinicians and researchers have begun to document their experiences and findings in working with such children. The historic lack of attention by health care and social service providers to the serious problems and service needs of these children can be attributed to many factors. The lack of research on the problems and needs of children of alcoholics and an inadequate system of dissemination of research findings have contributed to the lack of general awareness of the problems of children of alcoholics. However, lack of organized advocacy; concern for legal issues related to parental consent; and inadequacy of human, physical, and fiscal resources by established alcoholism treatment and human service programs are also important factors. Programs directed to children as the primary client are relatively rare. Services for children are most frequently outgrowths of programs that primarily provide family treatment services or alcoholism services.

In September 1979, the National Institute on Alcohol Abuse and Alcoholism sponsored a symposium on Services to Children of Alcoholics (NIAAA 1981c). The purpose of the symposium was to convene a representative group of professionals working to meet the needs of children of alcoholics. NIAAA invited program administrators, counselors, and educators to share their experiences and insights, to identify critical policy issues, and to assess future needs.

The symposium participants agreed that, in most cases, caregivers lack understanding of the urgency of the needs of children of alcoholics, as well as knowledge of the range of proven responses to those needs. Limited instruction in professional educational programs about alcoholism and its effect on family members contributes to producing physicians, educators, and social service personnel who often are not fully aware of the problems and are thereby limited in their ability to help their young patients, students, and clients to cope with one of the most potent and formative confusions in their lives. Symposium participants made the following points:

- Many education, health, and social agencies that become involved do not fully recognize the prevalence of parental alcoholism and the needs of the children in relation to it.

- In some cases, a lack of training leads to inaction because teachers and others do not know how to identify and properly address the needs of children of alcoholics.

- In some cases, service providers know that something should be done to help the child of an alcoholic, but they take no action because they do not know how to effectively use the information once they have it. A referral mechanism may not be known or readily available to them.

- Service agencies inadequately respond to clients from different cultures because so little is known about their specific needs and so few culturally relevant materials are available.

Purpose

To enlighten caregivers on how to identify, intervene with, treat, and prevent further problems with children of alcoholics, NIAAA has sponsored the development of resource materials for caregivers on issues and service needs of this population. In December 1980, NIAAA awarded a contract to develop the materials for this document.

The initial activity was an assessment of needs identified by more than 100 caregivers. Practitioners in several areas were targeted, including those working in family and individual therapy, health services, social work, alcohol and drug abuse treatment, research on social and psychological phenomena related to alcohol abuse and alcoholism, and education and child development.

Based on in-depth discussions with school personnel, health and social services agency personnel, researchers, and alcohol agency personnel, key issues and service needs of caregivers were defined. This document represents a response to those identified concerns by integrating existing information in the following areas:

- Identification of children of alcoholics, including their characteristic needs and problems, and appropriate procedures and settings for identification

- Prevention, intervention, and treatment, including appropriate strategies, the advantages and disadvantages of various settings for these activities, related legal issues, references to successful programs, and new program initiatives

- Training of caregivers, including appropriate academic training, professional background, skill and attitude development, and procedures for working with other professionals in related fields and facilitating changes in administrative procedures to bring attention to the needs of children of alcoholics

- Referral and support resources available in the community, including identification of financial, human, and programmatic resources typically available

- Cultural factors, including obstacles to and effects on program development and implementation

- Research directions, including findings on characteristics of effective treatment and prevention programs, factors affecting likelihood of an individual's becoming an alcoholic, and factors influencing the formation of personal relationships and future professional and social behaviors

Theories, research, and applications identified through reviews of the literature and original unpublished materials have been integrated and organized into four major sections: Chapter I presents an overview of the problems and needs of children of alcoholics; chapter II discusses the variety of approaches and caregivers appropriate to serving the needs of children of alcoholics; chapter III examines organizational issues; and chapter IV addresses cultural issues involved in service delivery, specifically to minority children. The appendixes provide descriptions of specific programs serving children of alcoholics and an annotated reading list.

Audience

This document is designed to serve the needs of a wide range of potential users, including:

- Experienced practitioners working with children of alcoholics in prevention and treatment programs

- Alcoholism practitioners with little or no experience with children from alcoholic families

- Professionals working in the related fields of education, recreation, health, and social services, who have little or no background in the alcoholism field

The initial needs assessment highlighted many areas related to the caregivers' training, setting, and clientele where these resource materials could be useful. Specifically, the materials can be used to:

- Build support for alcohol education training for teachers and curriculums for students in schools and recreational and correctional facilities

- Target children of alcoholics for services in alcoholism treatment settings

- Educate service providers in hospitals, social service agencies, religious organizations, and law enforcement agencies about the relationship between parental alcoholism and problems of children of alcoholics

Chapter I
Problems and Needs of Children of Alcoholics

Mary Williams has always appeared to be a strong, independent, and successful young woman. She graduated as valedictorian of her high school class, held several part-time jobs to finance her college education, and lived at home caring for her father and two younger sisters after her mother's death.

Billy Reed has consistently received good reports from his teachers. He is a cooperative, courteous student and, until recently, had always completed his assignments thoroughly and on time. His new eighth grade teacher, however, is concerned about his health. Billy's school work has fallen off and he is often listless and dreamy during class.

Paul Cranford has recently become a regular in the principal's office. He is repeatedly delinquent, loud, and defiant in front of his teachers. A leader in a group of boys identified by school authorities as potential dropouts, Paul has earned a reputation by acting tough with younger schoolmates, smoking in back stairwells, and interfering with organized school activities.

Mr. and Mrs. Clifton are called to court with their son Jim who has been arrested for driving while intoxicated, and meet with an educator from the local health department's alcohol safety program. The educator asks if there is a history of alcohol abuse in the family. It turns out that Mr. Clifton is a recovering alcoholic. The Cliftons are confused and upset. They feel their son should know better after having experienced living in an alcoholic family.

Focus Questions

Do all children of alcoholics have the same needs and problems?

How does alcoholism affect family life?

How does living in an alcoholic family affect children?

Introduction

This chapter describes the problems and needs of children living in an alcoholic family. The discussion begins with a brief summary of common explanations of alcoholism and then presents views on the dynamics of living in an alcoholic family.

Research on children of alcoholics is primarily based on theories about family member interaction. The research and experience of practitioners cited herein have shown that an understanding of the conditions of alcoholism and the kinds of problems symptomatic of alcoholic family life is important in identifying children of alcoholics. The lack of such an understanding can lead to misinterpretation of the reasons for some of the problems experienced by children of alcoholics.

This chapter discusses the general needs and problems of children of alcoholics and presents profiles of family life and members' behaviors. The profiles and types are simply examples. It is important to realize that individuals are more or less similar to these examples. However, caregivers should not be limited by these types and should be sensitive to the particular needs and behaviors exhibited by their clients. The needs of children of alcoholics have frequently been overlooked because they were not expressed in ways easily identifiable to traditional caregivers. What follows is a summary and comparison of different needs.

Do All Children of Alcoholics Have the Same Needs?

Children of alcoholics come from a wide range of backgrounds and exhibit a variety of responses to living in an alcoholic family. It is therefore difficult to identify children of alcoholics and to define their needs. The fact remains, however, that for these children, the drinking problems of their parents provide the central focus of their lives; their feelings, personalities, and social behaviors are affected more by this reality than by any other.

Mary Williams

During the active alcoholism of her mother, Mary Williams became extraordinarily capable. She assumed her mother's responsibilities as homemaker and mother. She had no time for personal friendships or dating. Friends and adults who were in positions to be caregivers were confident of her ability to handle any situation. Even when her mother died, Mary seemed willing to take on the problems of others.

Mary is the type of adult child of an alcoholic whose needs and problems frequently go unrecognized. Sometimes adults like Mary reach a point where they realize that family alcoholism has interfered with the development of their own lives. They may need therapy and a period of adjustment to start focusing on making their own decisions about career opportunities and social relationships. Others face their history of family alcoholism when they are treated for their own alcoholism or for the alcoholism of their spouses.

Adult children of alcoholics, like Mary Williams, can learn to apply knowledge of the coping skills they used in the alcoholic family to the successful shaping of their own lives. Such coping skills may have prevented them from developing positive relationships with peers and spouses. Skills developed for a particular situation should be reexamined as to the function they now serve. The carrying over of survival behaviors from the alcoholic family to a nonalcoholic family can be destructive. Adult children of alcoholics need to recognize attitudes and behavior that are no longer needed or useful once they are outside the alcoholic family life.

Billy Reed

As the child of an active alcoholic, Billy faces constant fighting between his parents every evening. He worries about his alcoholic parent's behavior when not at home, and worries about the safety of the other members of the family when the alcoholic is at home. He is unable to sleep at night, cannot concentrate on his work, and consequently does poorly in school. He is exhausted and has stopped eating properly, preferring not to be at the table when his parents are arguing. His physical health is deteriorating and successful performance in school is impossible.

Billy needs to be identified as the child of an alcoholic. This may involve questioning by his teacher and counselor, investigation of his home setting by a social worker, and medical care. Once his physical needs are being considered, Billy could benefit from participation in a combined educational/therapeutic program, for example, attending Alateen meetings and an alcohol education group run by a therapist. The goal of intervention by school and social service staff members would be to educate Billy about alcoholism and its effects on the family and to prevent him from becoming an alcoholic. With the help of experienced health, education, and alcoholism specialists, Billy should work on detaching himself from the responsibility for his family's alcoholism. Although he will not stop worrying about his family, he can learn to concentrate on his own needs.

Paul Cranford

Paul seeks the attention of authorities in school as a reaction to his alcoholic father's behavior at home. Paul has lost respect for his father, who blames Paul's mother for his alcoholism and is actively drinking to the detriment of his work and the support of his family. Paul feels that being a "big shot" in his peer group and around his neighborhood will bring status to his family's name, to replace that lost by his father's behavior. At the same time, Paul knows that what he is doing is wrong. He is so confused by his father's inappropriate behavior that he seeks attention and discipline from other authorities to clarify what is right and wrong.

Paul also needs to be identified by school authorities as a child of an alcoholic. A student counselor who is uniquely trained to work with substance abusers or members of a family in which there is substance abuse can help identify the problems underlying Paul's behavior. Paul's concern about the community's view of his family shows a desire to be an accepted member of that community. By participating in a peer counseling group in which he learns about the effects of alcoholism on family members, Paul can learn that he alone is not responsible for his family. He can also learn that there are methods of involvement in the community that will bring positive attention to himself and his family, such as starting a neighborhood job service or volunteering in a recreation program for younger boys.

Jim Clifton

The Clifton's son Jim is also the child of an alcoholic. It is not difficult to understand that he will be affected by his father's alcoholism. What is hard to understand is why Jim should be having drinking and behavior problems now, during the family's recovery.

The Cliftons must realize that Mr. Clifton's expectations of himself and his family have changed during his recovery. Mr. Clifton is trying to be a responsible father and citizen, trying to make up for the problems he feels were caused by drinking. He is more strict about his children's behavior, setting curfews and monitoring their use of alcohol. Jim, who was a tremendous help to his family before, is unaccustomed to and resentful of his father's new involvement. Jim wants to set his own limits. He also feels like breaking out of the disciplined life he led while helping his family. Jim found himself unable to let go gradually. He drank too much and was caught. Jim needs an opportunity to deal with his feelings about his drinking father and his "new" sober father.

Jim and his father and mother should work with a counselor to understand the new expectations each will have of the other family members. With family counseling Jim will understand that his contribution to the family is still valued. He may have to adhere to new rules, but if his feelings are respected he may be less resentful.

How Does Alcoholism Affect Family Life?

Common Explanations of Alcoholism

Throughout the discussion of issues about children of alcoholics, the point is made that the definition of alcoholism held by both the clients and caregivers affects (1) the type of services offered and (2) the use of these services.

In searching for an explanation of alcoholism, researchers have focused on the characteristics of the drinker. Kinney and Leaton (1978) reviewed this research and its overall finding that all alcoholics are not alike. Because there is little support for an explanation of alcoholism based on individual characteristics, alcoholism is explained by practitioners and researchers in terms of its consequences, symptoms, or origins.

The most frequently used explanations of alcoholism derive from the National Council on Alcoholism (NCA), Alcoholics Anonymous (AA), and the research of E. M. Jellinek (1960, 1962). These explanations refer to the symptoms and consequences of alcoholism as a disease.

According to the NCA/American Medical Society on Alcoholism Committee on Definition:

> Alcoholism is a chronic, progressive, and potentially fatal disease. It is characterized by tolerance and physical dependency or pathologic organ changes, or both--all the direct or indirect consequences of the alcohol ingested.
>
> (In: Alcohol and the family. Human Ecology Forum 9(3):7, Winter 1978.)

AA does not try to analyze why some become alcoholics while others do not. It views alcoholism as a disease affecting the family, work, and health from which one recovers by abstinence and participation in the AA fellowship of recovering alcoholics.

Both of these explanations have been influenced by the work of E. M. Jellinek. Jellinek, a biostatistician, defined alcoholism as "any use of alcoholic beverages that causes any damage to the individual or to society or both" (Kinney and Leaton 1978, p. 41). In the development of this definition, Jellinek studied a pattern in the progression of symptoms of alcoholism in over 2,000 members of AA. Four phases of alcohol addiction were described from this analysis:

- Prealcoholic. What is an apparent socially motivated use of alcohol in this phase also involves seeking psychological relief through drinking. The alcoholic seeks participation in activities where drinking is acceptable and uses the alcohol to handle problems and stress.

- Prodromal. Meaning warning or signaling disease, this phase is evident when the drinker has blackouts. During this time, the drinker appears to be functioning normally but has no memory of the events taking place. Other symptoms include sneaking extra drinks, feeling guilty about drinking behavior, and finding that looking normal while drinking takes great effort.

- Crucial. In this phase, the active alcoholic is not able to stop the drinking once it starts, and may begin drinking in the morning. Many strategies are used to avoid starting, such as declaring oneself on the wagon, moving to another city, and changing jobs. As these fail, the alcoholic becomes remorseful and resentful. Family and friends are affected. There may be periods of hospitalization.

- Chronic. The alcoholic's tolerance drops and intoxication may be day-long. Attendance at work is less frequent. Physical effects, such as tremors, are noticeable. The alcoholic in this phase may feel that he has hit bottom and may finally accept suggestions for treatment.

The Illness of Alcoholism and the Family

Traditionally, the illness concept of alcoholism has indicated that the alcoholic alone should be the focus of intervention and treatment. However, research on therapy strategies involving spouses and children has indicated that a relationship exists between alcoholism and family life (Steinglass 1976). Treating the whole family has resulted in improved control of drinking, greater persistence in therapy, and improved marital relations.

A treatment perspective known as family systems theory has increasingly been applied to the treatment of the alcoholic family. Many different therapists, psychologists, psychiatrists, and social workers working with the alcoholic family seem to agree that the family functions like a system. Each member has responsibilities; the system tries to maintain stability; there is a desire for organization and predictability of events and their consequences; and there are built-in feedback mechanisms.

When a family is dysfunctional it is not meeting the needs of its members. It is then necessary to examine what is happening to create an imbalance and work with family members who can change their behaviors and improve the system. This can be done with or without the involvement of the most dysfunctional member, such as the alcoholic.

Alcoholism has been called a "family disease" on this premise: that the sharing of the dysfunctioning behavior of the alcoholic by the other family members through the adoption of individual dysfunctional behaviors is like sharing the disease of alcoholism. Bowen (1973), Wegscheider (1981), and Steinglass (1980) claim that each family member plays a part in the dysfunctioning family. Some members adopt the same behaviors as the alcoholic, such as denying the problem and blaming it on external influences (Davis 1980; Bowen 1973). Jackson (1954), Fox (1972), Goodman (1978), and Shirley (1981) have described the integration of survival roles and behaviors as stages in the profile of an alcoholic family.

Peter Nardi (1981), Sharon Wegscheider (1981), and Claudia Black (1981) have studied the roles of the children and spouse in a family with an alcoholic member. Nardi, relying on role theory based in sociology, explains that for every member in a family there is a corresponding set of duties and rights based on position in the system, gender, age, birth order, ethnic custom, and social class. These duties and rights constitute a role for each family member. Roles change when definitions of a situation change (for example, a change in economic status due to loss of a parent's job) or when the family system changes (for example, when a parent dies).

Wegscheider (1981) describes the family as a mobile. The balance and flexibility of a mobile are essential to its existence. When there is an alcoholic in the family, there is a potential for imbalance in the family unit due to the unpredictable and often disruptive behavior of that member. Wegscheider believes that each of the other family members acquires a role to cope with the alcoholic behavior, thereby reducing stress and maintaining the balance. Wegscheider describes the following survival roles displayed by members of an alcoholic family:

- Chief Enabler. This person--often the spouse or parent--is often the one the alcoholic depends on most. As the alcoholic loses control, the chief enabler finds it necessary to put aside personal feelings and become more and more responsible for the family to make up for the alcoholic's lack of control.

- Family Hero. The family hero is especially sensitive to the family's problems. Feeling responsible for the pain of its members, the hero tries to improve the situation. This may be accomplished by trying to be a great success in an environment outside the home--work or school--to provide self-worth or positive recognition for the family. However, because this does not change the alcoholic's behavior, the hero ultimately feels like a failure.

- Scapegoat. The scapegoat does not wish to work as hard as the hero to achieve recognition. He chooses to pull away in a destructive manner, bringing negative attention to the family by getting into trouble, getting hurt, or just withdrawing.

- Lost Child. The lost child offers relief for the family by taking care of personal problems and avoiding trouble. The family ignores the child, who is then left to face problems alone. This strategy results in loneliness and personal suffering.

- Mascot. The mascot provides relief and humor for the family by being charming and funny during stressful times. While his behavior relieves the pain of some family members, it does not help the mascot deal with personal pain and loneliness.

Survival behaviors, Wegscheider believes, are carried by the individual from the family system to other relationships. Therefore, the alcoholic affects not only family member interactions, but also the

children's behavior with peers, other adults (teachers, relatives, religious officials, and law enforcement officials), and later, adult friends and spouses, as they seek to maintain the set of survival behaviors which are keeping or have kept them afloat in a most stressful environment.

The problem with carrying these behaviors over to other relationships is that survival roles are specifically related to a condition of alcoholism where there is denial of reality and repression of feelings. These survival roles are likely to conflict with the more traditional roles of children and spouse expected in other relationships (Nardi 1981).

The assumption and maintenance of survival roles also causes conflict within the alcoholic family as it proceeds through different stages. Confusion and inconsistency of expectations may be the origin of many of the problems of children of alcoholics (Seixas 1979; Black 1981; Woititz 1981).

A frequently noted source of confusion concerns the role of parent as disciplinarian. Whatever the sex of the alcoholic parent, children report that during active alcoholism, familiar rules concerning staying out late or dating may be abandoned. Children find that they can stay out as late as they like. The alcoholic parent does not care and the nonalcoholic spouse may be too involved in other problems to be aware of the lack of discipline. When the alcoholic stops drinking, new rules and restrictions, frequently a byproduct of guilt and genuine concern over the safety of the children, are imposed. Resentful of the restrictions and angry about the new involvement, children may rebel by consistently breaking the rules. Such rebellion represents a genuine conflict. Children may have longed for parental concern when the alcoholic was drinking; now they seem to disregard it.

Another familiar conflict is based on the familial responsibilities undertaken by children during active parental alcoholism. When parents are actively drinking, children may run the household and care for younger siblings. The recovering alcoholic generally tries to reassume these responsibilities. Children are asked to become children again instead of "little adults" or "parents." Unaccustomed to behaving like children, the transition back to more traditional roles may cause conflict between parents and children.

The adoption of survival roles by children in an alcoholic family means extraordinary behaviors become normal and realistic ones lose their meaning. When the family is in recovery and the need for survival behaviors ceases, the readjustment may be more difficult than the original adjustment to the dysfunction of the alcoholic parent.

Jackson (1954), Fox (1972), Goodman (1978), and Shirley (1981) have described stages and behaviors during active drinking and recovery periods of an alcoholic family. Their descriptions are currently the ones most frequently referenced in explaining the effects of alcoholism on the nondrinking spouse and the children.

- Denial of the problem. Incidents of excessive drinking occur but the alcoholic explains them away. The spouse tries to avoid the topic and tends to believe the drinking is not a problem. Trying to exert control meets with resentment and rebellion from the alcoholic.

- Attempts to eliminate the problem. As drinking episodes increase and last longer, the spouse tries to hide the problem from friends and employer. Drawing apart, the husband and wife examine reasons for drinking. They try to handle the problem themselves. The alcoholic spouse feels no one understands. The nonalcoholic spouse feels out of control and a failure. The alternate times of drinking and nondrinking impose conflicting requirements on the children. The nonalcoholic spouse is in conflict about whether to protect the children from the reality of drinking or to depend on them for everything and confide in them. The alcoholic may insist on attending functions with the children, embarrassing them with drinking episodes.

- Disorganization. This is a time of chaos in which the nonalcoholic spouse and children have developed strategies for avoiding or controlling the alcoholic behavior. The nonalcoholic spouse is frustrated and unhappy with his or her own responses to the drinking. Children can get no help or understanding from either parent about changing their family situation.

- Attempts to reorganize despite problems. At the onset of a crisis, such as lack of money to pay bills, or violence directed at spouse or children, the family begins to separate. Either the parents physically and legally separate or the nonalcoholic spouse reorganizes the life of everyone, leaving out the alcoholic. The reorganization may involve seeking professional help for the family, getting a job, and/or discovering AA and Al-Anon.

- Efforts to escape the problems. Either desertion by the alcoholic spouse or a decision to separate by the nonalcoholic spouse occurs. Children may be divided between parents or sent to live with relatives or older siblings.

- Reorganization of part of the family. Separated from the alcoholic, the family tries to establish a new life. However, the alcoholic spouse may still affect the family by calling, attempting violence against family members, or by working on their sympathy to gain a reconciliation.

- Recovery and reorganization of the whole family. If the alcoholic spouse achieves sobriety, whether or not there has been a separation, the family may attempt to reorganize. This involves dealing with problems long hidden by the alcoholism. It also involves acceptance of change in family roles from those

developed in order to survive and avoid the consequences of alcoholism.

Shirley and Shirley (1981) have described in more detail the phases in the recovery of the alcoholic and family, as gleaned from their work with alcoholics and adult children of alcoholics in therapy. The Shirleys view recovery as a developmental process in which everyone has different reactions, expectations, and objectives. The development phases described below are accompanied by the average length of time alcoholics could spend in each phase:

- Phase I: pretreatment, possibly as long as 20 years. This phase corresponds to the stages described by Jackson (1954) and Goodman (1978) in the previous profile of the alcoholic family. This is a time of chaos--members have tried and failed to stop the drinking, to get the alcoholic to admit that there is a problem. Children and spouse have learned to stay away from the alcoholic.

- Phase II: detoxification, 0-14 days. This is a brief and dramatic period during which the alcoholic stops drinking as a patient in a hospital or clinic setting or on an outpatient basis, giving the family relief and hope for the future. It should also be a time for looking for a treatment program for both the family and the alcoholic. Immediate involvement in a therapeutic program is essential to maintain the defenses of the alcoholic against recurrence of the drinking behavior.

- Phase III: rehabilitation, 3-6 months. The alcoholic in rehabilitation will exhibit behavior that is erratic and uncomfortable, but also will experience this as a "pink cloud" period. The alcoholic develops hope for the future and new energy to relinquish the denial system and stay sober for enough days to participate in the family system. The family "walks on eggs," afraid of slips, not sure how to behave. Relationships between spouses may be strained because, as yet, there are no permanent changes in the alcoholic's behavior.

- Phase IV: early sobriety, 1-2 years. During this phase, the alcoholic is recognizing problems always present but not handled during active drinking: emotional, job, and marital problems, and nutrition and other health problems. These are solved slowly. There is an overall feeling of resentment, fear, and anxiety as family members deal with feelings repressed during the active alcoholism.

  According to the Shirleys, during the early sobriety period, the alcoholic's work with AA is essential to the momentum of recovery. In reaching out to others, the alcoholic spends considerable time away from the family. This is hard for the family. Many families report a wish for a return to active drinking because then they knew how to behave to maintain a balance in the family. Ironically, the predictable behavior patterns of alcoholism are preferred to the unpredictability of sobriety. Also during this early phase, the nonalcoholic spouse may have physical symptoms such as fainting or illness. Such stress symptoms may be used to control the recovering alcoholic, to bring attention to him/herself, or to avoid conflicting feelings. The positive effects of recovery include reeducation of spouse and children. Spouse and children find new roles for themselves that are not alcohol related. All the family members plan for reconstruction.

- Phases V-VI: reconstruction and development, from now on. This is the time when members learn to deal with problems that were submerged during the family's active alcoholism. The family becomes more flexible in its interactions, realizing that rigid control is no longer necessary. A new style of communication evolves between family members. The alcoholic realizes anything is possible except drinking. The development of self-worth enables the alcoholic to go to other professionals to deal with other problems. The alcoholic realizes problems can be handled without drinking and that AA friends do not have all the answers. As a result, relationships expand and the family comes out of its isolation.

How Does Living in an Alcoholic Family Affect Children?

One of the purposes of these resource materials is to inform caregivers of the symptoms of family alcoholism observable in children of alcoholics. Recognizing these symptoms should help caregivers to identify, refer, and provide services to children of alcoholics. Information about observable symptoms is usually gathered by research with the target population. However, according to Nardi (1981), research on children of alcoholics has provided information with limited reliability and generalizability. In general, the research has lacked theoretical foundation, the data collection techniques and focus of research have been so varied as to inhibit comparison, and the samples have been selected from specific treatment settings without adequate control groups.

Those who have reviewed the literature (Nardi 1981; Wilson and Orford 1978; NIAAA 1980b) have discovered little solid evidence about the effects of family alcoholism on children. Associations between alcoholism and physical abuse, poor school performance, depression, suicide, and transmission of alcoholism may be strong, but any one of these problems could be a symptom of other conditions besides family alcoholism. Therefore, the caregiver

should be cautious in applying the following findings to children of alcoholics.

The following summaries are divided into general developmental periods during which alcoholism may affect children: fetal development, childhood, adolescence, and early adulthood. In the alcoholism field, the trend is to examine all potential effects of alcoholism (Whitfield 1980), to better match life stages of alcoholism, type of problem, and services provided.

Fetal Alcohol Syndrome

Research literature on Fetal Alcohol Syndrome (FAS) indicates that even in 1981 researchers and physicians could not agree on the actual amount of alcohol that is harmful to the fetus. Why mother's alcohol intake damages some fetuses and not others is a mystery. What is known is that alcohol ingested by a pregnant woman crosses the placenta, travels into the fetal tissues, and sometimes results in permanent physical effects.

Since 1972 substantial information has accumulated on alcohol and pregnancy. It is now clear that alcohol consumption in pregnancy is associated with a variety of possible adverse outcomes, ranging from isolated decrements in prenatal growth or complications of delivery to FAS with its associated mental retardation. Fully 50 percent of women who drink abusively during pregnancy give birth to children with alcohol-related birth defects or have pregnancy and delivery complications which place the infant at undue risk. Some of these children will be born with FAS. While the nonabusive drinker is not at risk to deliver a child with FAS, evidence exists to indicate that alcohol consumption at levels as low as two drinks per day is associated with decreased birth weight and may well be associated with an increased occurrence of spontaneous abortions.

Some reports indicate that the condition of pregnancy provides its own safety mechanism to help women control alcohol intake. Women report unpleasant aftereffects from drinking, such as nausea, stomach irritation, and diuresis. It is agreed that more education about FAS should lead to reduced alcohol intake among expectant mothers (Olson 1978; NIAAA 1981b). However, the barriers to detecting women with alcohol abuse problems inhibit reaching the women most in need of education, according to Sokol and Miller (1981). These barriers are (1) lack of attention by nurses and physicians to family history of alcohol use; (2) denial of the problem by obstetrics patients; and (3) patients' sensitivity to questions concerning their own and their family's drinking history.

Because recent research shows that alcohol consumption during pregnancy can harm the fetus, the Surgeon General advises women who are pregnant (or considering pregnancy) not to drink alcoholic beverages and to be aware of the alcoholic content of foods and drugs.

The Young Child and the Adolescent: General Problems and Needs

The consequences of living in an alcoholic family are particularly difficult for young children and adolescents. Although child development theories may disagree on how much, how early, and how long it lasts, the learning of values, beliefs, and the development of identity occurs whenever children interact with family members. The process of human development involves imitating behaviors of adults, siblings, and peers; modeling behavior after the valued characteristics of others; and developing individually distinctive behavior by integrating the behavior learned through interaction with others. The interaction with other people, events, and the environment combines with emotional, physical, and mental needs to guide the process of development.

Children, adolescents, and adults learn differently during the various stages of development and need different kinds of support and information from family, peers, and their environment. Understanding the stages and corresponding needs helps put in perspective the symptoms children of alcoholics may exhibit.

According to Wilson and Orford (1978), the research on symptoms has given inadequate consideration to the child's age, sex, relationship to drinking and nondrinking parents, relationship to siblings, and sex of the drinking parent in explaining alcoholism effects. What is reported most frequently are negative effects on children in general, such as:

- School problems: absenteeism, temper tantrums, fighting with peers, trouble with adults and schoolwork (Haberman 1966; Morehouse 1979)

- Emotional disturbances affecting social and family relationships: greater difficulties in maintaining family and social relationships, emotional instability, maladjustment to reality, lower self-regard and self-acceptance, greater difficulty in accepting one's own aggressive feelings, greater need for support from others, higher external locus of control, higher rates of suicide and chronic depression (Weir 1970; Kammeier 1971; Chafetz et al. 1971; O'Gorman 1975; Cork 1969; Fine et al. 1975; Ackerman 1978; Richards 1979)

- Physical health problems: psychosomatic complaints, hyperactivity, neglect and abuse, effects of FAS (Nylander 1963; NIAAA 1980b).

Woititz (1981), Booz-Allen & Hamilton (1974), Cork (1969), and Ackerman (1978) have described a number of problems characteristic of children of alcoholics that have emerged during interviews and clinical work with children of alcoholics of all ages.

- Emotional neglect and physical abuse. Children of alcoholics are frequently left alone or under the care of siblings, relatives, and

neighbors. Without the emotional support of either the alcoholic parent or the nonalcoholic spouse, children are vulnerable to physical abuse by one or the other parent. Children are blamed for problems of the family and are verbally harassed.

- Family conflict. There is a great deal of fighting in the alcoholic family. Children report being unable to do homework or even eat dinner at home. Their rooms become havens from the family fighting.

- Inappropriate parental behavior. Parents confide their sexual, health, and financial problems to their children. Children are unable to understand some of these problems and feel helpless to solve others. When children are with their friends, the alcoholic may embarrass them by sexual inuendos and poor hygiene.

- Parental illness, divorce, death. Children of alcoholics may react to many illnesses of their parents, the confinement of parents to hospitals or mental institutions, the death of either parent, or the divorce of parents and remarriage. During illnesses, they may be confused about their separation from the ill parent and genuinely worried about possible death.

  When parents separate due to alcoholism, the family may not break cleanly. Children go from one parent to the other. If one parent is still drinking, children are forced to experience the same problems the nondrinking parent is avoiding by the physical separation.

  During a divorce, children may be used by the nondrinking spouse to gain support payments and may be asked to testify before a judge. The adjustment to visiting both parents may be more difficult when the nondrinking parent remarries and the children are expected to keep up with new rules and a new stepparent.

- Confused feelings. The ups and downs, family conflict, abuse, and neglect lead to confused feelings. Children of alcoholics may resent the alcoholic but feel protective and concerned about this parent's health. Children may love and admire the nonalcoholic parent for keeping the family together, but resent the nonalcoholic's lack of sympathy for the alcoholic. The splitting of feelings, love and hate, leads to feelings of guilt. There is embarrassment over the chaos and dysfunctioning of the family, confusion over what is right and wrong, and guilt about a powerlessness to make things right.

- Long-term consequences. According to Woititz (1981), long-term consequences of living with an alcoholic parent affect future work performance, social relationships, and family relationships. Children of alcoholics:

  - Have difficulty learning to have fun
  - Judge themselves critically
  - Have difficulty following a project through to completion
  - Overreact to changes they cannot control
  - Feel estranged from others in a group
  - Are loyal in the face of undeserving loyalty
  - Become easily locked into a direction without considering the consequences

The young child. Young children of alcoholics might seem to be protected from the negative consequences of family alcoholism because of their immaturity and inability to evaluate the situation. In fact, children at the first grade level and in early and late adolescence manifest the most symptoms, according to Bosma (1975). Even young children under the age of 5 recognize the difference in shapes of bottles and associate them with feelings about the contents (Reilly 1981).

The stages of child development--infancy, early childhood, play, and school age--are the times when children are learning how to trust adults and themselves, how to become independent within family rules, and how to identify capabilities and develop competencies. It is a time of developing a good self-image based on positive feedback from adults about one's behavior and getting a sense of reality from watching others interact.

Living in an alcoholic family, with the inconsistency of parents' care, the disharmony between parents and other family members, and the lack of support for each member's development, makes it difficult to develop a meaningful sense of reality. For example, young children are confused when parents deny the drinking problem or refuse to talk about it. The young child may view the alcoholic parent as two different people, one good and one bad (Richards 1980).

Young children do perceive the emotional disruption and are fearful for the drinking parent's health. They may develop a fear of going to school because of concerns that harm will come to the alcoholic while they are away. They may feel responsible for the drinking and at the same time resentful of lack of care. They may receive physical abuse from either parent because they are too young to fight back. The consequences would seem to be most serious if the alcoholic is drinking throughout the youngster's early childhood, when the child has no accurate perspective of what is normal and what is real. Feelings would be systematically repressed. Therefore, normal interactions with peers and especially other adults at school and in the community would be affected by the patterns of behavior already developed to deal with the alcoholism.

The adolescent. For the adolescent there is a slightly different set of consequences. Adolescence is a time of development of analytical skills and of heightened emotional sensitivity. The process of separating oneself from one's parents and becoming confident of one's identity and sense of values is full of conflicts.

Adolescents frequently reject their parent's values in the process of affirming their own identities. They later recognize that the search for this identity is inextricably tied to attitudes and values learned as members of their families. Adolescents in alcoholic families have little support for their identity development. They see parents behaving in socially inappropriate ways and getting away with it. Adolescents are disciplined for these same behaviors, often leading to their confusion in judging right from wrong.

Adolescents are frequently required to take parental roles in an alcoholic family, doing housework, driving siblings to activities, and standing in for parents at school and community functions. This may have a positive effect in the long run for they may become achievers in school and later at work, confident of being able to handle any problem and situation.

A negative effect is also possible: adolescents may become accustomed to taking responsibility without considering their own needs and problems. The assumption of additional family responsibilities may interfere with successful accomplishment of schoolwork and interaction with peers. The expectations and responsibilities imposed upon adolescents by the alcoholic and the rest of the family may not respect the gender of the adolescent. A male adolescent may be pressed into taking on an alcoholic mother's role in childcare while the father is working. If the father is alcoholic, the male adolescent may be expected to act as man of the house, even to supporting the emotional needs of the nonalcoholic spouse. The confusion over gender-related roles and feelings may result in longer lasting emotional effects than the lack of time to do schoolwork or play with friends.

If the alcoholic is actively drinking, the adolescent's home may be in a state of disarray and the nondrinking parent absent because of lack of interest or avoidance. The adolescent may be unwilling to bring friends home or to develop friendships at all, trying to hide the family's problem. When friends are brought to the home, the inappropriate alcoholic behavior may keep them from coming back.

Children of alcoholics, out of touch with facts about alcoholism, may assume no one has similar feelings. Therefore, they may feel isolated in any group of their peers. At the same time, adolescents realize they are missing the attention and support others receive. The anger and resentment they may feel, however, is in conflict with guilt about directing their anger at a parent who is obviously out of control and often ill. Anger may also be directed at other adults, such as teachers, who are unrelated and therefore seem safer targets.

Adolescents worry about the health of the alcoholic and may feel sympathetic. A reluctance to cause additional pain to the alcoholic and shame to the family by exposing the family secret may prevent girls, for example, from reporting physical and sexual abuse by alcoholic fathers. In addition, caregivers report that children feel guilty and assume that their behavior has encouraged the attack.

The Young Adult

General problems. Children of alcoholics attending college or living independently from their families also suffer the consequences of belonging to an alcoholic family. College students making successful new lives for themselves away from their families may be full of conflicts about their success (Donovan 1980). The positive self-regard achieved from these new experiences during separation from the alcoholic environment may be threatened by feelings of guilt and irresponsibility. Young adults may worry about the alcoholic and feel they should be taking care of their parent, not enjoying a new life with less responsibility.

Trips home during vacations may be avoided to maintain a physical and emotional distance. Upon returning home, children of alcoholics may find their roles and rooms filled by other siblings; they may feel left out of the system that maintains the family during active alcoholism.

Young adults who must live at home for economic reasons while working or attending school have a more difficult time making a transition from one reality to the other. They are still considered part of the family. Expectations of their survival roles are likely to persist if parental alcoholism remains active.

Once young adults establish themselves in jobs and develop intimate relationships, the effects of family alcoholism that have been hidden for years may suddenly emerge. Roles developed for survival in the family become inhibitors of successful personal and working relationships, although Black (1981) theorizes that these roles may in fact assist young adults to develop competencies essential to professional and personal accomplishment. Sudden breakdowns are reported by clinicians working with highly successful professionals. Children of alcoholics, previously nondrinkers, may become alcoholics and/or choose alcoholic mates, thereby recreating the alcoholic life patterns of parents and grandparents.

Intergenerational transmission. Perhaps the most insidious consequence of family alcoholism is the apparent transmission effect of the illness from one generation to another. For the offspring of alcoholics, the decision to use alcohol may be an issue of control. Children of alcoholics believe that the knowledge they have gained of the effects of alcoholism by watching their family will help prevent their own alcohol abuse. Adolescents in Alateen make comments about getting "blitzed" with friends. They then add, "Of course, it's not like I'm an alcoholic or something." There seems to be confusion over whether being able to choose to drink is equivalent to having control and, therefore, not

being an alcoholic. The fact is that children of alcoholics are at least two to three times as likely to become alcoholics themselves.

Researchers have tried to identify the origin of alcoholism to explain whether the transmission mechanism is biological or environmental. In a brief review of research on explanations of the transmission of alcoholism, Wolin et al. (1980) cite evidence from animal and human studies that there may be a genetic influence on alcoholism transmission. For example, in studies of twins, half-siblings, and adoptees testing genetic versus environmental explanations, a genetic factor in transmission was found to apply only to severe forms of alcoholism. This research does not exclude environmental influences from playing a part in intergenerational transmission. Goodwin and Schuckit are the two chief researchers in this area (Wolin et al. 1980).

Other work by El-Guebaly and Orford (cited in Steinglass 1978, p. 9) indicates three factors affecting the emergence of alcoholism: (1) "increased incidence of parental loss in the history of an alcoholic spouse"; (2) "social disruption and antisocial behavior, especially during adolescence and in the history of adult alcoholics"; and (3) "differential child rearing patterns."

Another avenue for investigation has been parental drinking practices and family interaction patterns. For example, research has shown that parents' drinking behavior and attitudes toward drinking are related to teenage drinking but not to alcoholism.

However, studies of family interaction patterns have shown positive relationships between behavior during active alcoholism and alcohol abuse by children in that family. Observations of seven couples during periods of experimentally induced intoxication by Wolin et al. (1975) indicate that their interaction during active alcoholism is similar to what both spouses said occurred in their parents' and grandparents' marriages. This suggests that certain individual behavior characteristics persist as the family alcoholic system is perpetuated in different generations of the same family (Steinglass 1978).

Wolin and others have studied the effect of alcoholism on family rituals, defined as events in which the family participates in activities to communicate special feelings and thoughts, for example, birthdays, graduations, marriages, deaths, and holidays. Rituals are important stabilizing mechanisms of internal family life. They clarify roles and expectations of the behavior of family members and give meaning and identification to a family. Rituals are usually modeled after those of earlier generations, although some young families begin new ones, incorporating elements of the old.

In their research, Wolin et al. (1980) examined the disruption of rituals by active alcoholic parents by interviewing alcoholic families. They discovered a relationship between disrupted rituals and the transmission of alcohol problems to the children's generation. In these transmitter families, members failed to respond to intoxicated behavior during rituals. When the alcoholic's participation changed, families accepted it. In nontransmitter families, members rejected or confronted the alcoholic parent or each other when intoxication interfered in the event; family members protected the rituals.

Since family rituals are a time when children gain a sense of family relationships, appropriate expressions of feeling, and a sense of spiritual or religious importance, the way a family chooses to handle the alcoholic member during these occasions is of some significance in understanding the consequences of alcoholism.

Summary

Alcoholism has been defined as an illness indicating that, for the alcoholic, there are expected symptoms, prescribed treatment, and hope for recovery. However, the family is also affected by alcoholism. Research and clinical experience indicate that a whole system of behaviors and strategies is developed to handle the alcoholic family member and maintain the family's economic survival. As the system develops, individual members may acquire unusual responsibilities that conflict with traditional expectations. The conflict over expected behavior, the physical and emotional abuse inflicted by the alcoholic, the lack of a sense of reality, and the repression of feelings are major effects of parental alcoholism on the children.

Understanding the relationship between alcohol abuse and family life is essential to providing services to children of alcoholics. The gaps in this understanding far exceed what is known. Additional information is needed on the relationships among the following elements of living in an alcoholic family:

- Age and sex of the alcoholic parent
- Duration of active alcoholism in relation to children's age and sex
- Variations in drinking patterns and drinking-related behaviors over time
- Atmosphere of day-to-day family life
- Parental problems other than alcoholism
- Relationships with friends and members of the extended family
- Violence in the family
- Role and family task arrangement (Wilson and Orford 1978)

In the next chapter the relationship between the problems of children of alcoholics and the services available is discussed.

Chapter II
Helping the Children From Alcoholic Families: Approaches and Caregivers

Jim Wright considers himself an involved citizen of his small community. To help those less fortunate than himself, he volunteers once a month to be a Big Brother. His Little Brother Tom although happy at first, begins to be late for their meetings. He participates less enthusiastically in the ball games they play and in selecting their future activities together.

Jim decides to speak to the administrator of the Big Brother program about the changes in Tom's behavior. Coincidentally the administrator calls Jim at work one day to tell him Tom may drop out of the program. "Tom's mother is an alcoholic," he tells Jim. "Have you noticed any changes in Tom's behavior? Have you made any effort to speak with him about what may be bothering him?"

Jim responds, "I don't think I could be involved in Tom's family problems. I do care about him, but what can I do to help? If he is having problems at home or in school, shouldn't he see a specialist?"

Focus Questions

What are appropriate approaches for meeting the needs of children from alcoholic families?

Who are the caregivers of children of alcoholics?

What are the gaps in services to children of alcoholics?

Introduction

In chapter I, the problems and needs of children from alcoholic families were discussed. Chapter II explains the most frequently used programmatic strategies to reach and help children of alcoholics and the types of caregivers and the contexts in which these strategies are applied.

What Are Appropriate Approaches for Meeting the Needs of Children From Alcoholic Families?

Needs of Children of Alcoholics

The literature reviewed in chapter I identified many of the needs of children of alcoholics and indicated that all have different living situations and different problems. Therefore, this discussion can only reflect upon some of the needs identified through a review of the literature and talks with caregivers, and the matching programmatic strategies.

Children of alcoholics need first to be noticed and identified as having special needs. For many, the behaviors symptomatic of living with an alcoholic parent will have alerted caregivers to their problems. However, many children learn survival roles that enable them to successfully live with their families without calling attention to themselves. Therefore, they remain unidentified. Chapter IV points out that minority children of alcoholics have particular problems in being identified. Cultural practices of solving problems with family or community resources prevent the identification of these children. In general, unless behavioral or emotional problems have led children to service professionals knowledgeable about alcoholic families, children are not likely to be the focus of services.

Children of alcoholics are frequently the victims of physical and sexual abuse. They urgently need to be protected by medical, social service, and law enforcement personnel.

Children of alcoholics are at high risk for the development of alcoholism or alcohol-related problems. Therefore, if they have not already participated in an alcohol education program, most children need information about alcohol and the consequences of alcoholism.

The mixed messages children receive about alcohol-related behavior may lead to confusion about sensible and socially appropriate behavior. Alcohol education can help children understand the dynamics of their families. It can acquaint them with

the services related to alcohol abuse within their community and thereby facilitate their seeking help if they must do this by themselves.

The emotional and behavioral problems symptomatic of living with an alcoholic family create needs for treatment and assistance. Depression, low self-esteem, poor school performance, and trouble with school and juvenile justice authorities are typically handled by therapy or educational counseling.

Strategies of Response

Responses to the needs of children of alcoholics are generally classified in four categories: identification, intervention, treatment, and prevention. In the reality of programing, these four response strategies have been linked and even integrated. It is sometimes difficult to identify a particular program as being either an intervention or a prevention effort. For example, an alcohol education program may seek to inform young people about substance abuse and its effects on a family. The participation in some of the program activities may make the youth feel comfortable enough to discuss family problems related to alcohol. In this way, a youth may self-identify as a child of an alcoholic.

Similarly, discussion of alcohol abuse may lead a youth to interact with a teacher, counselor, or an alcoholism specialist. Counseling about family problems may be one result. Another may be an intervention, such as the youth's participation in a peer counseling program or referral to a treatment program.

Identification. Identification is the process of determining which children's parents are alcoholics or have other alcohol-related problems. Though not always a prerequisite to providing help, the primary advantage of identification is that it allows direct attention to be focused on the child. If possible, a next step is to identify the appropriate services that can be made available to the child.

Intervention. Intervention may be the direct or indirect contact with the child of an alcoholic for the purpose of increasing awareness of the child's problem. Intervention may be the most general of the four strategies; it may refer to any effort to reach out to the child. At the same time, it is used to refer to a complete programmatic effort with unique personnel.

Treatment. Treatment of the child of an alcoholic is a systematic effort to address the child's problems and alleviate them, whether through psychotherapy or medical care. Treatment may address the behaviors symptomatic of living with an alcoholic, but it does not lose sight of the origin of the problems, considering them unique to the child's situation.

Adults often possess, or can muster under stress, both internal and external resources to cope with alcoholism in the family. Without this experience and knowledge to draw upon, the child is at a disadvantage (Will Foster, personal communication, March 1982). Ironically, the nondrinking spouse may actually prevent the child from being helped. The denial of the drinking and an attempt to conceal family problems frequently prevent the nonalcoholic spouse from seeking help for the children. The child is therefore in a position of attempting to survive almost unaided. At such times, any attention may enable the child to survive the situation.

There are as many different goals of treatment as there are differences in needs among children. Most clinicians report that helping the child express the confusion and deep feelings resulting from living in an alcoholic home should be the primary objective of treatment. Social workers, psychologists, and psychiatrists believe that a corrective emotional experience leads to healthy development and the integration of realistic behaviors that will help the child survive in the family and in the real world.

Prevention. Prevention is a strategy that assesses the individual's potential or present development of problems and prescribed interventions to prevent the occurrence or reduce the severity of the problems. Primary prevention activities focus on identifying high-risk groups and reducing the incidence of alcohol-related problems in the youth population. Secondary prevention activities, sometimes called intervention activities, are directed to youths already demonstrating alcohol use problems. These activities seek to reduce the number of these youths and avoid their progression to a stage of severe difficulty. Tertiary prevention activities, also known as treatment activities, are directed at the problems experienced by youths who are abusing alcohol.

Since children of alcoholics have a high risk of developing alcohol abuse problems, prevention activities are especially relevant to them. Alcohol education and the development of healthy coping skills are prevention goals appropriate for children of alcoholics with or without alcohol problems of their own. Primary prevention activities can help identify children of alcoholics and refer them to other needed services.

Who Are the Caregivers of Children of Alcoholics?

The caregivers of children of alcoholics can come from any professional field and can provide many different kinds of help. This section discusses the historical treatment of the alcoholic and family in terms of the services provided for them. Changes in the kinds of professionals and the contexts in which services are provided to children of alcoholics are specifically addressed.

Caregiver for the Alcoholic Family

Conflicting views within communities and professional disagreements concerning the setting and

personnel involved in alcoholism treatment have contributed to a lagging understanding of the needs of alcoholic clients and definition of the appropriate caregiver (Booz-Allen & Hamilton 1974).

AA was the first large-scale movement in the United States with a treatment orientation toward alcoholism. It began in 1934 and was followed in 1938 by the founding of the American Research Council on Alcoholism (Pittman and Sterne 1965). At Yale University, the Quarterly Journal of Studies on Alcohol was begun in 1940. The Yale Summer School of Alcohol Studies was established as the first national training institution for alcoholism personnel. The School of Alcohol Studies later moved to Rutgers University where it exists today as a training and clearinghouse facility. In 1945 the National Council on Alcoholism (NCA) was founded to promote the concept of alcoholism as a disease. Its founder, Mrs. Marty Mann, was a student of Jellinek's at Yale and the first female member of AA.

The change in orientation that NCA intended to promote led to a change in State, local, and Federal policy on alcoholism. State authorities, who previously regarded alcoholism as a problem related to the sale of alcoholic substances and the control of the public inebriate and drunk driving, now became concerned about alcoholism as a mental and public health problem. In 1943 Oregon established the first State public health program directed at alcoholism (Pittman and Sterne 1965, p. 203).

In communities, heavy drinking was variously seen as a moral or religious issue by interest groups and as an economic issue by the alcohol industry. The American Medical Association did not accept the notion of alcoholism as a disease until 1956. This opened the way for hospitals to treat alcoholics and develop training programs for medical personnel. Both activities, however, were slow getting underway. AA remained the primary resource for alcoholics and families seeking help.

Today, despite the 11-year history of NIAAA and the support of a network of State Prevention Coordinators, Mental Health Administrations, and associations representing alcohol personnel, disagreements persist regarding the basis of alcoholism. Some caregivers with a psychiatric orientation view alcoholism as a symptom of mental disorders. Others with sociological and anthropological orientations view it as a symptom of social disadvantage and cultural pattern. Some researchers believe alcoholism is hereditary.

This disparity of views affected the community's determination of the responsibility for the care of the alcoholic's family (Pittman and Sterne 1965). Alcoholics may come in contact with medical, psychiatric, social welfare, family service, judicial, or special alcoholism personnel and settings. The spouse and children of an alcoholic may also come into contact with this varied group of personnel and institutions due to the alcoholic's and their own physical, emotional, and economic problems. According to an analysis of service institutions in a sample of typical communities, Booz-Allen & Hamilton found a lack of efficient and focused services for the alcoholic's family (Booz-Allen & Hamilton 1974; similarly, Pittman and Sterne 1965).

Booz-Allen & Hamilton's report for NIAAA identifies service policies of the variety of institutions as blocks to reaching family members. The report cites a tendency to respond to the client demands rather than needs, the lack of a referral system, and the attitudes of personnel who care for the alcoholic family as factors in a history of inadequate services, especially for the children of alcoholics.

Caregivers for Children of Alcoholics

In providing services to children of alcoholics, caregivers have started to cross over to each other's settings and integrate each other's professional fields, setting precedents in an area where little has been accomplished.

Historically, children of alcoholics have been treated for the symptoms of living in an alcoholic family, such as child abuse, incest, troubled behavior, poor grades and school absences, and depression. Experts in services to children of alcoholics emphasize that caregiving starts with the competence to see past these symptoms and identify family alcoholism as the problem. An effective community service system develops this competence in all its service providers.

Caregivers for children of alcoholics may be school personnel, including teachers, counselors, and nurses; medical personnel, including doctors, nurses, and psychiatrists; social service counselors, psychologists, and psychiatric social workers; youth workers and law enforcement personnel; recreation personnel, including volunteers and experts in youth recreation and sports activities; and church representatives.

School. The school is a major institution involved in alcohol abuse prevention. Over the past 10 years, as substance abuse on school grounds has become a community issue, schools have tried innovative programs, even combining education with undercover law enforcement.

Schools are constrained by the concerns and rights of parents in the kinds of programs they can offer. Treatment or counseling, other than the accepted activities of guidance counselors and nurses, must be approved by parents. Therefore, reaching children of alcoholics, even through approved treatment programs, can be especially difficult, as the alcoholic and the nondrinking spouse may deny that there is a problem and may well discourage their children from talking to strangers about their family life.

Still, schools are an ideal place to perform the following services for children of alcoholics: information sessions about alcoholism and alcohol use, referral to community agencies for special services, school peer groups to discuss adolescent problems and alcohol issues, preparation and acquaintance with Alateen, and identification of children of alcoholics through supportive alcohol education programs.

Generally, teachers have been involved in education activities and school counselors or nurses in referrals. However, Triplett and Arneson (1978) interviewed school nurses attending a national professional convention and found that, although the nurses recognized problems symptomatic of living in an alcoholic family, most felt they needed more knowledge and skills before they could consider becoming deeply involved with the children displaying these symptoms.

Recently, two programs have trained teachers and social workers to address the needs of children of alcoholics in schools. One program developed by the Westchester County Department of Community Mental Health (see appendix A) places social work professionals with extensive adolescent counseling experience in schools. These student-assistance counselors (SAC) present alcohol education sessions to teachers and students and conduct group sessions for students who have special concerns, including concerns about alcohol and drug abuse. Confidentiality is strictly maintained. In an effort to minimize the peer attention typically paid to students with problems, the SAC program does not identify the groups by name, such as "children of alcoholics group."

Working alongside guidance counselors in schools involves careful identification of one's responsibilities and regard for those of other professionals in the school. As degreed social workers, the SACs have one foot in the mental health profession and one in the educational profession. This could lead to difficulties in responses to their services from both professions. To alleviate any role-related conflicts, the continuing inservice program for SACs focuses on problems emerging from working with school and community service personnel.

The SACs receive an intensive 3-week training program before taking their positions in schools. This includes a study of medical, legal, psychological, psychiatric, social, and cultural aspects of alcoholism and alcohol abuse as well as assessment, prevention, treatment, and referral of children of alcoholics. School principals select the SAC with whom they feel most comfortable, taking into account student body characteristics, cultural background of the counselor, and school needs.

Another training program prepares teachers to deliver an alcohol education curriculum in schools. This program has been developed and implemented by the Cambridge-Somerville Program for Alcoholism Rehabilitation (CASPAR) in Somerville, Massachusetts (see appendix A). According to the developers of this curriculum, teachers must deal not only with their own attitudes toward drinking but also with their attitudes toward youth and drinking. Teachers are a chief resource in the identification of children of alcoholics, as many of the problems stemming from living in an alcoholic family emerge in the school and in peer groups. The program developers believe that introducing alcohol education to adolescents through a course is a nonthreatening way to relate the concept of prevention and is more effective than sending them to a counselor to deal with the ensuing problems of alcohol abuse.

In the CASPAR training program for teachers, participants learn how to communicate information about alcohol and alcohol abuse to their students. Most important, they learn how to deal with children of alcoholics who identify themselves as such. Teachers learn to emphasize that:

- The child of an alcoholic is not alone.
- Parental alcoholism is not the child's fault.
- Alcoholism is a disease.
- Alcoholics do recover.
- Children need and should get help for themselves.

Because teachers and other school personnel are often unfamiliar with counseling students with these kinds of problems, they may have concerns about the responses and needs of children who identify themselves as children of alcoholics. The CASPAR training program teaches its participants to establish a relationship with their students before introducing a potentially disturbing subject like parental alcohol abuse. The program emphasizes that teachers have referral resources in their community that they should know how to use if a crisis with a student develops or if they need to obtain more preventive assistance. (Contact CASPAR, Cambridge-Somerville Mental Health Center, Somerville, MA, for more information.)

With the addition of focused training material directly related to professional role and clientele, both the SAC and CASPAR training programs are appropriate for the nonalcoholism professional. This indirect service provider has the most potential as the caregiver who identifies children of alcoholics, educates them about family alcoholism, and knows how to get them the specific help they need.

The advantage of reaching children of alcoholics through school education and peer counseling programs is that the students are already in an environment where they feel relatively comfortable. They do not have to initiate contact with a community agency or treatment setting. In addition, school and peer counseling programs can reach a larger number of children than a treatment or prevention program in an agency treating alcoholics.

There are also disadvantages to conducting counseling programs in school. First, the school program can become so convenient that participants do not follow recommendations to participate in treatment programs or in Alateen. Students may come to rely on peers or teachers to solve problems for them, although solving their problems may require more sophisticated knowledge than peers or teachers possess. Therefore, it is especially important that school personnel attempting to reach children of alcoholics establish good relationships for referral with community agencies and private treatment providers. Often this will require educating child welfare agencies, child protective agencies, and juvenile justice personnel to look at children's be-

haviors as the symptoms of living in an alcoholic family.

Youth agencies and associations. This broad group of settings includes correctional halfway houses for runaways and youth with substance abuse problems, recreational associations in communities, and churches sponsoring youth social development.

The potential caregivers in each setting are equally diverse in background and training. There may be mostly volunteers in a local Big Brother program, in addition to experienced youth workers and social workers. In halfway houses, there may be a range of certified and noncertified substance abuse counselors and outreach workers. Church-sponsored youth groups may be under the guidance of ministers or trained social workers.

The variety of caregivers indicates that different strategies to identify and serve children of alcoholics will be appropriate depending upon the expertise represented among the personnel in each setting. Identification of children of alcoholics is facilitated by intake procedures in correctional and runaway centers. Identification in voluntary associations like the Boy Scouts or church social clubs would be more informal, probably through knowledge of youth over a period of time.

If these settings are sponsored by local government health and youth departments, some of the caregivers will likely be certified as professional counselors. In this case, education and even therapy groups may be possible for treatment and prevention approaches, with the permission of parents. If youths are ordered to these settings by the juvenile justice system, treatment would not require the permission of parents.

The advantages of reaching children of alcoholics through youth-related settings stem from the interest and needs that bring youth to them. Some youths must participate because of a court order. Some have nowhere else to live. Youths who are voluntary participants in social clubs or recreation associations have a level of interest upon entering the group that facilitates involving them in other educational activities.

The disadvantages of these settings relate to inconsistency of training among the caregivers. Where no treatment program can be established to help children of alcoholics identified at the setting, referral resources and relationships with appropriate treatment settings are essential.

Treatment settings. Treatment settings include hospitals and private and public agencies. The caregivers typically found here include physicians, nurses, psychologists, psychiatrists, social workers, and alcoholism counselors. They may be trained in the nature of alcoholism and its effects on the individual and the family. However, according to the literature reviewed earlier, there is little effort underway to train professionals in these fields to be advocates for children of alcoholics.

Treatment settings can provide services for the whole family, including family therapy and family alcoholism treatment. Groups can be sponsored for education and therapy of spouses, other relatives, and children. Educational groups for children may coincide with those for parents. In such groups, children can deal with their feelings about family alcoholism and be helped in their development of healthy responses to the family situation. They can be introduced to Alateen as their parents participate in AA and Al-Anon. Children and parents can be counseled together to improve their relationships with one another.

The chief advantage of a treatment setting is the potential for identifying children of alcoholics and involving them in treatment corresponding to that of their parents. However, some treatment settings focus on the alcoholic alone or on the alcoholic and the nondrinking spouse. In other settings, where children are being treated for emotional problems, caregivers have not been as involved as they could be in identifying parental alcoholism as a possible cause of the children's problems. Therefore, family alcoholism itself does not become the object of the treatment strategy.

Rustin (1981) has written about the role that physicians and nurses should take in identifying family alcoholism and focusing treatment efforts on this. Because of their knowledge of the medical symptoms of alcoholism, physicians are in an excellent position to diagnose alcoholism and its effect on the family as the problem. Unfortunately, many physicians prefer to focus on the medical consequences of the illness alone.

Professional associations for medical and therapeutic personnel could support a change in the way their members treat family alcoholism. Some professional associations, such as the one representing social workers, do specifically refer to the problems of children of alcoholics in their statements on alcoholism. Policy statements and the support of training efforts in professional degree-granting programs would help focus the attention of treatment caregivers on the problems of children of alcoholics.

The constraints on treatment settings in reaching children of alcoholics relate to the processes by which they receive clients. Hospitals help alcoholics and family members when a serious medical or psychiatric problem exists, but other family members are not generally brought into an accompanying treatment program. Agencies that provide residential or outpatient services for recovering alcoholics are limited in reaching other members of the alcoholic family or the children of alcoholics, unless these potential clients are referred through other health and social service institutions. Therefore, the relationships between treatment settings are especially important in reaching alcoholics and their families.

Once in place, coordinated intake and identification procedures and decisionmaking approaches for referral should facilitate assistance to all members of an alcoholic's family and decrease the chances that children will fall through the cracks of the system of health services. The expansion of services is also important. Bringing on full- or part-time caregivers who are specialists in the problems of

children, or even sharing such specialists between treatment facilities, will increase the kinds of services provided. Because they see only the families of the alcoholics they treat, treatment setting personnel are sometimes limited in their clientele. Expanding services with skilled caregivers will enable the setting staff to reach out with prevention and identification services to other treatment and referral sources in the community.

Attitude of the Caregiver

Regardless of professional position, all caregivers who become involved in working with children of alcoholics will need particular training to develop the knowledge, skills, and healthy attitudes toward alcoholism and alcohol use needed to work with this population. They will find that their attitudes about their own drinking will be tested. They may have trouble separating their work experiences from those in their personal lives. They may bring home the problems of their clients and respond to their friends and family members in dramatically different ways.

Individuals who train nonalcoholism and alcoholism professionals agree that an examination of personal attitudes toward alcohol use is essential to the development of healthy approaches to working with the alcoholic family. Unless feelings about personal drinking habits are examined, they are likely to affect one's tolerance of the alcoholic and family members who have been unable to intervene successfully. Once professionals are working with alcoholics, their attitudes are very difficult to change, even through special training. DiCicco et al. (1978) and DiCicco and Unterberger (1977) have reviewed the literature on professional alcoholism caregiver training. They found that large increases in factual knowledge about alcoholism result from typical alcohol education programs, but that minimal changes occur in attitudes.

In a training program, people respond to information about alcoholism based on their own patterns of drinking, not as professional treaters of alcoholism (DiCicco and Unterberger 1977). The training process seeks to promote an understanding of one's own drinking behavior compared with that of one's peers. For some it will bring out an unconscious fear of becoming an alcoholic (Bailey 1970). The discomfort initially experienced by professionals in training may be positive in the long run. Bailey indicates that once professionals have left the training experience and returned to or entered active practice, this discomfort will be applied to practical experience and will be reduced. The examination of attitudes toward drinking and alcoholism should result in the identification of real drinking problems for those who have them and a reassurance and elimination of guilt for those caregivers who drink appropriately.

Working with children seems to affect caregivers personally. This is amplified with children of alcoholics. Caregivers need gratitude and support just as other individuals do. Their self-esteem is drawn to some extent from their accomplishments with their clients. Since alcoholism can be a most difficult problem to resolve, caregivers are at risk for depression and "burn-out" as the frustration of working with alcoholic families and the bureaucracy within service institutions builds. Strong feelings about alcohol use by friends, relatives, and family members may interfere with personal relationships. Caregivers may become intolerant of those who do not take the effects of drinking seriously.

Caregivers may need their own self-help groups to resolve the issues emerging from working with children of alcoholics. Whether such help is provided by their own institutions, through special alcohol study institutes, or by professional associations, it is essential to maintain the caregivers' commitment to and involvement in the services they provide. Another important and widely available vehicle for combatting professional burn-out is through attendance at meetings of AA, Al-Anon, or Alateen.

The Medical Foundation, Inc., surveyed 1,106 graduate students in an NIAAA study to determine their expectations and attitudes regarding the treatment of people with alcohol-related problems. The respondents were students in nursing, medical, and counseling programs in or near the greater Boston area. The results indicated that the surveyed students already believed that they could not help or solve the problems of certain clients they were being trained to serve. One-third of the respondents felt that few people are able to overcome their drinking problems. Two-thirds foresaw an eventual relapse of recovering alcoholics. One-half seemed to think that of the many examples of treatment given, none was identified as very good. Most respondents rated AA as a very good source for alcoholic recovery, even though they were aware that AA does not directly involve caregivers in its own work with alcoholics and their families (NIAAA Information and Feature Service, April 1, 1982).

The survey results indicate that even though more professional programs for caregivers--such as social workers, nurses, and physicians--include curriculum components on alcoholism and the family, attitudes of the caregivers themselves may serve as barriers to the effective treatment of the alcoholic and the family in the long run.

What Are the Major Gaps in Delivery of Services to Children of Alcoholics?

Inadequate working relationships between relevant service agencies, lack of dissemination of knowledge about the needs of children of alcoholics, lack of active programs and materials, and lack of training programs for caregivers are the major gaps in service delivery. In addition, research on the needs of children of alcoholics, as it shapes program development and training, is an area of concern.

Confusion Over Working Relationships Among Groups

Children of alcoholics interact with many different agencies, both public and private. The types

of services available and their relationship to one another vary from community to community.

In some communities there is a local nonprofit affiliate of the National Council on Alcoholism (NCA). NCA councils, consisting of representatives of community, industry, and public service institutions, serve as an advocacy group for alcoholic families, support local service providers with in-service training, and even support alcohol education programs in schools.

Local NCA councils seek financial resources from contracts with local governments, grants from foundations, and individual contributions. Therefore, the amount of money available to service providers from local councils may vary from year to year.

Local funding sources such as the United Way, local government, and volunteer associations also vary as to the kind of support they give to services. Agencies may have different working relationships with these funding institutions from year to year.

The lack of coordination between funding agencies, regulatory agencies, and service agencies has led to confusion about where to get information, financial support, and training. A community resource is needed that either filters information, directs people to the appropriate place, or offers all information, training, and financial support.

In Washington, D.C., the Washington Area Council on Alcoholism and Drug Abuse, Inc., publishes a guide called the Coping Catalog. This is a referral guide to treatment resources for inpatient and outpatient care, detoxification units, residential facilities, self-help groups, legal aid, and military facilities. It also contains essays about alcoholism related to the family, the employer, the attorney, and the counselor. In Rockland County, New York, the Mental Health Association publishes a newsletter about its services and includes inspiring stories of the people who have used them. These dissemination efforts are highly worthwhile.

At the same time, communities may need an umbrella organization composed of agency and institution representatives concerned with health and social welfare issues. An umbrella organization could review the policies and practices of agencies, help casefinding, and act as an advocate for unique clients such as children of alcoholics. The board of such an organization could establish referral procedures to increase the caseloads of those agencies best able to meet the needs of different client groups based on their staff and facilities. Irrelevant referrals to and from other agencies could be decreased. An ongoing review of examples of cases would help the agency representatives maintain an awareness of community problems in referral and service delivery.

Knowledge Dissemination

Effective and ongoing local and State efforts to disseminate existing community information are inadequate or nonexistent. The National Clearinghouse for Alcohol Information (NCALI) collects fugitive and published materials about programs and materials for children of alcoholics. This information is not getting out to local communities systematically, however. At the recent National Council on Alcoholism Forum, for example, many people working with children of alcoholics were unaware of an NIAAA published monograph about services to children (NIAAA 1981c).

NCALI disseminates upon request many materials on alcohol abuse prevention for use in schools, including alcohol education curriculums from the replication projects (NIAAA 1980c) sponsored by NIAAA. These projects, although they have been cited as potentially valuable for identifying children of alcoholics in the schools, do not primarily focus on the issues faced by children of alcoholics. Because there is so little documentation available in general about programs for children of alcoholics, the lack of comprehensive treatment in these curriculums is especially noticeable.

At present, there is little or no effort at the national level to develop programs and materials specifically focused on the needs of children of alcoholics and addressed to the caregivers of these children.

However, some informal networks of caregivers working with children of alcoholics do exist. In some areas, caregivers are forming advocacy councils for these children. Unfortunately, the unavailability of economic support for such widespread advocacy and dissemination activities makes the future of such councils look gloomy.

Lack of Active Programs and Materials

The clearest gap in services to children of alcoholics is the lack of active, sustainable programs focused specifically on them. More and more treatment settings are sponsoring short-term treatment groups for the families of alcoholics. Sometimes these groups include unique educational and therapeutic groups for children. Many communities begin programs for families and children with the financial assistance of the Federal Government, seed money from foundations, and even private individual contributions, but, once the initial financial resources are expended, many programs end. Without a plan to institutionalize such programs there is little chance of sustaining them. In the past decade, NIAAA has taken the lead in developing innovative programs for children of alcoholics. NIAAA backing has helped programs obtain additional support from State and local advocacy groups and alcoholism administrations. Currently, however, NIAAA's role is limited. Program development and institutionalization now depend on the priorities set by States in their use of block grant funds.

The only national program for children of alcoholics is Alateen. In general, Alateen participants can feel comfortable knowing that wherever they move they will be able to connect with another group. The basic format and content of the groups remain the same, making the specific location unimportant. However, there may be a lack of Alateen groups in university communities. Once young adults

have left home and are attending college they may require a slightly more adult composition in their groups--to deal meaningfully with the issues of separation from the alcoholic family, for example. More Al-Anon groups for children of alcoholics seem warranted.

Along with the gap in educational and therapeutic programs, there is a lack of materials service providers could use with children of alcoholics at all ages. Art therapy materials developed by Claudia Black are frequently used for very young children. Other programs refer participants to nonfictional materials developed by AA and Al-Anon. Books such as The Secret Nobody Knows, by Cathleen Brooks; Living with a Parent Who Drinks Too Much, by Judith Seixas; and Francesca Baby, by Joan Oppenheimer, are more appropriate for preadolescents and teenagers. There is nothing for the young adult and little for the very young child except comic book representations of alcoholism, such as Pepper, by Elaine Melquist. The comic books have been criticized for their harsh presentation of alcoholism and lack of explanation of ambiguities for the very young child. Writing a comic book about such a serious subject seems to be a basic contradiction that children are not able to resolve. Lacking specific materials, programs often adapt activities used in educational and therapeutic settings for their clients who are children of alcoholics.

Lack of Training for Caregivers

Very little in the way of training for caregivers and volunteers could be documented. Most information in the field is written for those working with alcoholics. Degree and certification programs prepare caregivers to work with the family as a whole.

Many caregivers who become involved with the family through referrals from alcoholism treatment agencies adapt the theory of their disciplines, psychology and psychiatry, to the problems they are treating. No specific training could be documented for caregivers of children of alcoholics. The most relevant educational experiences for caregivers in this area are represented in the CASPAR alcohol education curriculum and the Student Assistance Counselor training, both of which introduce the caregiver to the needs of children of alcoholics.

Lack of Research on the Needs of Children of Alcoholics

The research reviewed here indicates how little is known about children of alcoholics. Most studies have been limited to interviews with children whose parents are in treatment. The difficulties in obtaining control and experimental groups, and the problems of confidentiality, have inhibited researchers in planning studies of the differences between children who live in alcoholic families and those who do not.

The gaps in research were enumerated by caregivers and practitioners interviewed in the needs assessment completed for this document and literature review. They are:

- Successful strategies of casefinding
- Effective curriculums for training staff of programs not treating alcoholics
- Developmental needs of children of alcoholics
- Risk-taking behavior of children of alcoholics
- Formation of relationships with peers
- Development of sex-role identity
- Attitudes toward drinking taught by children of alcoholics to their children
- Cultural attitudes toward alcoholism
- The effects of intervention efforts on peer relationships, school achievement, and later work and social experiences
- Factors interacting with parental alcoholism which affect children, such as parents' age and sex, siblings, and the child's age and sex

Summary

This chapter examined the roles and responsibilities of the caregiver working with the child of an alcoholic. The history of providing services to the alcoholic is inextricably tied to the slow development of professional concerns for this target group.

Almost anyone can be a caregiver. Some professionals provide services directly related to family alcoholism; others can support efforts by direct service providers by identifying and referring children of alcoholics. Whether one is a direct service provider or acting in a referral capacity, some general and specific training is necessary. General knowledge about alcoholism, alcohol, and the effects of alcoholism on the family are basic and required. Then, depending upon the setting in which one works, one's background and experience in the alcoholism field, and the contact one has with children, special training experiences should be developed.

Since it was founded, NIAAA has sponsored the development of numerous training programs for all types of caregivers. However, changes in policy and funding during the 1980s will affect the development and availability of these programs. It will most likely be incumbent upon the National Council on Alcoholism (NCA) and its community affiliates; professional associations; and local, State, and regional mental and physical health services to maintain a concern about the sponsorship of this training for caregivers working with children of alcoholics.

Training is important, but caregivers are sometimes additionally limited in their response to the needs of children of alcoholics by the settings in which they work. Traditional response strategies of identification, intervention, treatment, and prevention are appropriate to certain settings. For example, prevention activities like alcohol education classes are accepted in schools. Prevention activities are also appropriate in alcoholism treatment agencies. Caregivers and potential caregivers must weigh the advantages and disadvantages of a particular strategy, considering the number of clients they will reach, the kind of help they can provide, the limitations of their own training, and the constraints of their setting.

A number of gaps exist in providing service to children of alcoholics, many due to a lack of foresight and a coordinated approach. These gaps include lack of coordinated relationships among funding, regulatory, and service agencies; lack of knowledge dissemination; lack of active programs and materials development; lack of caregiver training; and lack of research on the characteristics and needs of children of alcoholics. Resources should be devoted to narrowing these gaps. Support for services to children of alcoholics would probably motivate more individuals to reach out and offer help.

As a potential caregiver, Jim Wright can assist his Little Brother by participating in a training program. With an understanding of the effects of family alcoholism on children, and knowledge of community resources available to help Tom, Mr. Wright can offer positive assistance and encourage Tom to remain in the Big Brother program.

Chapter III

Organizational Issues in the Provision of Services to Children of Alcoholics

Mr. and Mrs. Wilson have been participating for 2 months in individual and couples' therapy at the Newson County Outpatient Treatment Center. This is part of a family effort to recover while Mrs. Wilson is recovering from her acute alcoholism.

Mr. Wilson is very pleased about the changes in his relationship with his wife. However, he is concerned that their children are not the direct focus of similar services. He knows the outpatient center does not have a program for children of alcoholics. He decides to talk with his counselor Steve Lawrence about this.

Focus Questions

What kinds of agencies respond to the needs of children of alcoholics?

How does identifying the child as the primary client affect an agency?

How are programs developed and financed?

Introduction

The previous chapter compared settings, including the school, where caregivers are found and the services and the constraints of each. This chapter describes the kinds of agencies found in a typical community as they relate to serving the needs of children of alcoholics, the services they provide, and how they are funded. A case example of developing and financing a new program with children of alcoholics as the primary clients is presented.

What Kinds of Agencies Respond to the Needs of Children of Alcoholics?

In a typical community, a number of institutions and agencies provide services to children of alcoholics. These may or may not be related to a formal institutional structure and they may be public, private, profit, or nonprofit. They may or may not recognize a problem of parental alcoholism being faced by a child receiving their services.

A city or county government is responsible for particular health, education, recreation, law enforcement, juvenile justice, and social services for its residents. The health department supervises public programs in hospitals, clinics, and homes, including the visiting nurse program. The education department supervises the operations of the school system. The recreation department sponsors after-school and summer park activities. The human resources department addresses the needs of disadvantaged youth and youth at risk due to parental abuse. It also addresses the emotional and physical problems of families through services in mental health centers and clinics, and provides help for alcohol and drug abuse problems through hotlines, detoxification centers, and rehabilitation programs. The law enforcement and juvenile justice departments supervise personnel and operations of institutions such as halfway houses and youth correctional facilities. Alcoholism treatment and prevention programs may be sponsored by one or more of these departments.

In a community there may also be a variety of private institutions offering some form of service to children of alcoholics. These may include hospitals with alcoholism treatment services for the family and psychiatric services for children; private psychiatric hospitals; and private social work, psychology, and psychiatric practices.

Private nonprofit agencies such as Jewish Social Services, Catholic Family Services, and Pastoral Counseling provide treatment for children and families in the form of psychological and psychiatric therapy. These agencies are sustained by member contributions, client fees, insurance payments, fundraising activities, and the contributions of the United Way and local affiliates of national service organizations. The agencies provide a variety of opportunities to reach children with alcohol-related problems, but do not generally identify the children of alcoholics as the focus of their services. For example, in a private service agency, one staff member may have particular training or experience

in family alcoholism. This staff member's availability may be the only reason the agency becomes involved in family alcoholism and delivery of services to children of alcoholics.

Private nonprofit organizations may also operate residential alcohol and drug abuse programs, such as Phoenix House and Odyssey.

Voluntary organizations like the Scouts, Parent Teacher Associations, the JayCees, and the Junior League often develop education and prevention materials, give grants for community agencies and schools to develop and operate their own programs, and even run their own programs with the help of trained staff. Churches and synagogues may sponsor youth education and social activities conceived as substance abuse prevention programs.

Nonprofit advocacy, fundraising, and funding groups like the United Way, local affiliates of the National Council on Alcoholism, and youth coalitions rely on volunteers and paid administrators to promote communication among service institutions, develop programs, and disseminate information about successful programmatic and management issues.

Sometimes the relationship between the sponsoring agency and the agency delivering services is a formal one, with signed contracts, evaluation procedures, and staff supervision requirements. For example, a county mental health division sponsors a school-based counseling program as a demonstration project with NIAAA support. The administrator of the program is located in the mental health administration offices and supervises the training of the counselors. The contract is with the local education agency, and each school principal has final approval over the hiring of counselors.

In another county, a nonprofit voluntary advocacy group, specifically, the community mental health association, plans and provides alcohol abuse services to the county's population via a mental health center. The county contracts with the mental health center to provide the following services:

- A 24-hour detoxification environment
- A 2-week inpatient program for medically supervised detoxification and early rehabilitation
- Outpatient clinics at the center and at five satellite sites for information, evaluation, and counseling
- A day treatment and rehabilitation program
- A family education program
- An employee assistance program for county employees
- Consultation and education activities for community businesses and institutions
- Training workshops for social and health professionals
- An alcohol hotline
- A cultural awareness and educational program for youth
- Counseling and activity groups for children of alcoholics

Some specific programs reaching children of alcoholics are described in appendix A.

How Does Identifying the Child as the Primary Client Affect an Agency?

In the history of providing services to the alcoholic family, first the alcoholic and later the spouse were identified as primary clients by treatment settings. Children, whether or not from an alcoholic family, have been the primary target of alcohol prevention and education programs through recreational and educational settings. More intensive education and treatment efforts are often appropriate for the needs of children of alcoholics, and it may therefore be time for treatment settings to examine their services for this client group.

Treatment settings have had much contact with the children of alcoholics. However, caregivers report that the contact generally has been initiated to solve what basically may be the symptoms of family alcoholism. These symptoms include poor school performance, vandalism, crime, emotional breakdown, and physical abuse. The relationship of these symptoms to the parental alcoholism may not be recognized nor accounted for in the services rendered.

Referrals between agencies and institutions have always been important to "finding" clients with these symptoms. The referral process can be used to help identify children of alcoholics as primary clients due to parental alcoholism. Referral of cases from one type of institution to another, for example, from a school to a social service agency, requires the development of both information contacts and formal arrangements. The informal contacts are based on personal referral experiences between professionals who have come to trust each other's abilities. The formal arrangements are based on the mandate or mission of the agency, its staff capabilities, and its caseload.

Conflicts between agencies due to differences in these characteristics have created difficulties in serving children of alcoholics. When agencies direct their services to the alcoholic, have no staff trained in child and adolescent development, and have heavy caseloads, they are not able to meet the needs of children of alcoholics. Similarly, when an institution or private facility views itself as serving the behavioral or psychological problems of youth and is unconcerned about the role of parental alcohol abuse in these problems, it is reluctant to focus on family alcoholism and may not cooperate in the referral process.

Agency Missions

When dealing with the issue of referral for the child of an alcoholic, it is important to remember that the titles of agencies and institutions can be misleading in terms of the services they offer and their ability to adapt to this client's needs. The title "human services" does not necessarily indicate an emphasis on alcohol and drug abuse, and the title "mental health center" does not always indicate that inpatient, detoxification, and rehabilitation services for alcoholics are available.

Agencies generally have broad mission statements. It is important to look beyond these to identify the actual services provided and the referral activity they can manage for a client. In an agency established to serve alcoholics, the agency's philosophy about alcoholism--for example, its belief that alcoholism is a family disease--is likely to affect the type of services offered and broaden the focus of the staff to include the specific needs of children.

This focus can change, however. For example, in one outpatient program for alcoholics, an administrator was hired to run an education program for the children of the program's alcoholic clients. The demand for the education program, as well as for a therapeutic program, was soon confirmed. Referrals from probation officers, family courts, school guidance counselors, school psychologists, AA and Al-Anon, and other alcoholism service components in the community were consistently made to the children's component (NIAAA 1981a).

The agency found that starting an educational and therapeutic program for children was assisting in the process of casefinding for other staff, as some children participating in the sessions were identified as alcohol abusers in need of treatment themselves. A new educational and therapeutic program evolved with the child of the alcoholic as the primary client.

This example illustrates that the agency's perception of itself is an important element in the change process. A treatment agency does not typically consider itself a source of prevention programs. Because children are often the focus of prevention activities in school and recreation settings, service agencies do not allocate their limited resources to this program area. However, prevention is really a component of treatment, especially in the case of alcoholic families. Therefore, providing prevention services would meet both the needs of children and the mission of the agency.

Staff Concerns

Agencies with services relevant to children of alcoholics are composed of staff with different backgrounds. Staff activities during the intake process, their documentation, and their consultation with each other and with other caregivers are factors affecting the nature and extent of services provided for children of alcoholics.

Depending upon the mission of the agency, intake procedures may or may not elicit information about the alcohol history of the client's family. Formal procedures help identify children of alcoholics among families seeking treatment and among children referred for treatment of behavioral, physical, and emotional problems. The Door and the Rainbow Retreat are two examples of programs making efforts to obtain as much information as possible about the family's history of alcohol use, although caring for children of alcoholics is not their major concern. The Door might receive referrals of youth who have polydrug addictions. The Rainbow Retreat clients are seeking shelter from spousal abuse. Yet both programs recognize the importance of comprehensive history taking. This enables staff members to combine their backgrounds and experience in treatment to best serve the needs of the clients.

The documentation of client cases is especially useful in identifying client needs and planning program activities. A record of the number of clients with alcohol-related problems and the number of referrals received may be used as justification for additional staff, new training experiences for the existing staff, and new relationships between service and sponsoring agencies.

Whether public or private, an agency can provide consultation and education services to the community concerning parental alcohol use and its effect on children. Mental health centers as well as social service agencies can sponsor outreach activities, such as presentations to school and recreational personnel, church and business groups, and other service agencies, about the types of services necessary to help children of alcoholics. The consultation process is also a method of establishing referral connections between agencies and thus both expanding and focusing the caseload of the agency.

Developing or expanding services to meet the needs of children of alcoholics can pose difficulties at the staff level of an organization. Establishing a new therapeutic program, for example, can create tension between new and old staff. The original staff members may feel that they should be trained for any new responsibilities, and they may resent new staff members for taking away those portions of their cases that specifically relate to the new services.

Consultation procedures established at the beginning of a new program may help ease this tension. If staff members are clearly aware of their job responsibilities and a formal structure exists for handling problems outside of one's professional domain, everyone will be able to function with the same expectations of each other and of the agency.

A new program sometimes requires a change in the operational hours of an agency. In the case of children of alcoholics, if a program is offered in an agency, it is best offered after school or in the early evening, perhaps coordinated with aftercare sessions for their parents. This will allow students to receive the treatment they need without interrupting their schooling. However, the required change in hours will directly affect the staff. Some staff members with appropriate skills will have to work in the

evening, requiring the development of a rotation system. New staff may be hired specifically to handle the new caseload during this period.

Many nonprofit agencies use volunteers in certain roles to free professional caregivers for attention to their caseloads. Other agencies may use volunteers in educational programs or during intake procedures. Volunteers are necessary and important, but it is essential to carefully delineate their responsibilities and be aware of the liabilities involved in their performance of certain tasks.

Volunteers have been the cement that has held the alcoholism service field together. Starting with AA and leading to the development of the National Council on Alcoholism and its affiliates, volunteers have promoted the concept of alcoholism as a treatable illness.

In 1978, NIAAA initiated the Volunteer Resource Development Program (VRDP). State-operated programs encourage statewide networking of volunteer groups and promote their training. VRDPs were demonstration programs funded at 3-year intervals. As Federal support declined, the goal of the program was to help each VRDP become self-supporting. Innovative fundraising strategies and training materials for State directors and their local volunteer group associates were discussed at meetings of State VRDP directors.

In general, VRDPs do not focus on children of alcoholics. However, the Cottage Program (Boswell and Boswell 1982) sponsored by the Utah VRDP, has directed the public's attention to the needs of children through television public service announcements about "the kid in the bottle." Graphic vignettes showing the problems children experience with an alcoholic parent are directed at increasing community awareness of and financial support for the Cottage Program's education efforts. The Cottage Program sends trained volunteers into neighborhoods to evaluate community interest in holding education groups about family alcoholism. Trained group facilitators then conduct the education groups in the neighborhood.

Another volunteer effort underway in Charlotte, North Carolina, involves linking volunteer organizations with local city councils, churches, and social clubs to encourage minority volunteer participation. The Minority Volunteer Task Force sponsored a statewide conference on alcohol problems and developed public information materials.

To enhance the skills of volunteers, an agency can sponsor the volunteers' participation in training courses developed by the training divisions of their State Alcoholism Authority, the National Center on Alcohol Education, the Volunteer Resource Development Program, or consultants hired to provide inservice training. The volunteers may not wish to become social workers or accredited alcoholism counselors, but sensitivity to the needs of children of alcoholics and related issues of family alcoholism developed through a training experience can only improve their competence in performing appropriate agency assignments.

Lack of knowledge about referral resources and service responsibilities may be the chief barrier to serving the needs of children of alcoholics. By validating the success of a program, training old and new staff to handle new responsibilities, and disseminating information about the program to encourage use of its services, most programs, regardless of setting, can become institutionalized.

The setting and the staff should not be considered constraints to helping children of alcoholics. Working within the limits of staff training and the mission of each setting is possible. For example, alcohol education programs in schools can serve prevention, identification, and intervention goals without upsetting the parents of participating students. A youth center in a church can provide education and counseling by hiring experienced social workers and psychologists to lead educational and recreational activities. A private clinic and a public outpatient program can have parents in treatment at the same time their children are learning to cope with family alcoholism.

Children of alcoholics need not be underserved in any community. The appropriate professionals and settings are there. Awareness and communication between these people and agencies are what is needed to match services with the needs of this client population.

Legal Constraints

A number of legal issues surround the provision of services exclusively to children of alcoholics and their families. These range from the nature of services provided to the election of those services to the exchange of information among caregivers about clients.

The issue of parental consent for health care is complex. According to John M. McCabe (1977), it is somewhat difficult to determine precise limits for a child's own consent powers. Children may consent to the ordinary contacts of their daily life without parental involvement, for example, talking with teachers or school guidance counselors about drug or family problems. Children can also consent to advisory kinds of communications from professionals, although this may resemble treatment.

Until recently, rulings by the Supreme Court seemed to indicate that the laws controlling consent procedures were becoming less constraining. Recently, however, State and Federal legislatures have been trying to pass laws that require young people to obtain parental consent for abortions and for birth control information from health clinics. There may be liabilities for treating children without the consent of the parent, especially for nontreatment institutions such as schools. It is best to review one's own State laws to determine these liabilities. The rule of thumb is that it is always best to obtain parental consent before treating a minor or planning a treatment program in a nontreatment setting.

Whether a program offered for minors is educational or therapeutic, parents' rights to obtain their children's records are protected. The Buckley Amendment Family Educational Rights and Privacy Act of 1974 protects information collected about a

family from researchers. However, parents may obtain information about their children's activities in school, and this includes children's participation in alcohol education and support groups.

Service providers themselves are required to maintain the confidentiality of their clients undergoing treatment of alcoholism. Unless a life-threatening situation arises, caregivers are not allowed to discuss information with anyone outside the agency without the written consent of the client. For example, if a counselor in an alcoholism agency receives a referred case from the probation department, the counselor must obtain a signed release from this new client in order to release information about treatment back to the probation officer. A release of information consent must be obtained for each person with whom information about a client will be shared.

In addition to confidentiality laws, there are laws defining procedures for turning cases over to particular agencies, for example, to the police and protective services. This affects the reporting of incidences of child abuse by caregivers working with the children of alcoholics, including teachers, counselors, and medical personnel.

The nature of the client population an agency may serve is sometimes mandated by the bylaws of the agency or by local and State laws governing geographical service delivery areas. Community mental health centers, for example, have designated catchment areas from which both their advisory boards and clientele may be drawn. Some private nonprofit treatment programs have no such restrictions. Others, such as the Jewish Social Services, are constrained by the source of funds for particular services. If funds come from a nondenominational source, the program must be advertised as nondenominational.

How Are Programs Developed and Financed?

Once an agency has identified a need to serve children of alcoholics as a client group, it may require additional funding. The vignette in the beginning of this chapter takes Mr. Wilson to his counselor to discuss the need for a program directed at his children. The following is a hypothetical case study of how such a program could be developed and where and how necessary funding could be obtained.

Steve Lawrence is a counselor working for a county health department in the alcoholism treatment program. He has worked in this position for the past 3 years. During this time, Steve has noticed an increase in the concern expressed by parents about the effects their alcoholism may have on their children. Several of the parents have suggested that their children attend a program to deal with these issues. At a staff meeting, Steve asks the other counselors if they have also noticed this phenomenon. They have, and they communicate this new trend to the program director, Carolyn. Carolyn agrees to investigate funding options for a new program for children of alcoholic parents and to let the staff know the results of her inquiries.

The first thing Carolyn does is to investigate the state of the art of programs for children of alcoholic parents. She finds that a monograph including program descriptions has been written as the result of a symposium on children of alcoholic parents (NIAAA 1981c). She purchases a copy and then orders a computer search of literature on the needs of and responses to children of alcoholics from the National Clearinghouse for Alcohol Information. When Carolyn has finished reading this information, she has a fairly good idea of current programs and lessons learned. She then holds a staff meeting and reports her findings.

The staff members at the alcoholism program then hold a brainstorming session to determine the kind of program that would work best for their clients. The county in which this program is located is composed of different cultural groups and socioeconomic levels. Any program would have to be sensitive to the problems of these groups, such as lack of transportation, varied work schedules, and unfamiliarity with the service delivery setting.

After many discussions and meetings, Carolyn writes a plan for a program for children of alcoholic parents. The program she develops has several components:

- Education - The program will offer alcohol education for the children of clients at the clinic at the same time the education is being offered to the adults, that is, in the early evening, once a week. The education program will also be used as an outreach technique to the schools.

- Counseling - Counseling will be offered to the young people individually and in groups, after school for those youth who can come at that time, or in the early evening for those who are busy with jobs or extracurricular activities.

- Seminars - Program staff will offer seminars to various groups targeted for adult children of alcoholic parents. Offered as an "Alcohol and the Family" seminar, the program will stress children and the specific problems and concerns of adult children of alcoholics.

- Family therapy - Family therapy will be offered to family groups who are identified as requiring this service. Since social workers are well trained in family work, one position will be filled by a social worker. The other position will be filled by a trained youth worker.

- Evaluation - The program will be carefully evaluated by the county evaluator to determine what it accomplished in terms of improved family relationships, increased knowledge about alcoholism, and improved self-concept of the children.

Now that Carolyn has the program outline, she writes a proposal with a summary and projected budget. It is important to notice that the program is compatible with the services and staff already at the agency. Carolyn now goes to community agencies whose missions are consistent with those of her agency to gain their support for her program. Some of the agencies she visits are the Alcoholism Advisory Committee, the Office on Children and Youth, the Task Force on Youth Problems, and the local board of education. Carolyn meets with representatives from other service agencies to inform them about the program and plan referral relationships.

Carolyn's agency is nonprofit. Therefore, she will try to seek the support of a number of public and private institutions and focus less heavily on client ability to pay. In profitmaking agencies and institutions, client fees and insurance coverage are the primary sources of financing programs.

In nonprofit agencies, a sliding scale fee based on income is used. Client fees are anticipated to fund roughly one-fourth of the program for children of alcoholics. Due to budgetary constraints, the agency is unable to fund the program to any greater extent.

To solicit funds, Carolyn makes an appointment with the deputy director of the State Alcoholism Authority. The State has decided to use block grants for alcohol and drug abuse to fund primary prevention programs. Carolyn finds she may be able to submit her proposal for funding and get a small amount of money.

Next, Carolyn has a computer search done at the Foundation Center in New York City to determine which foundations are likely sources of funds for education and prevention. She applies to two foundations for grants.

Carolyn also holds a fundraising drive in her community and involves some of the major corporations in this effort. She decides to have an auction with donations from corporations and individuals.

An estimate of funds potentially available from health insurance of clients is made. Many States, including Maryland, require that insurance companies pay for alcoholism coverage. However, this is for alcoholism treatment. For children of alcoholics, therapy for problems related to a parent's alcoholism would fall under the category of psychiatric problems and coverage would depend on psychiatric coverage, which varies greatly among insurance companies. Health maintenance organizations sometimes limit the number of visits for psychiatric care. Insurance companies usually have a visit-per-year limit as well as a total dollar limit. Carolyn thinks that, although a small amount of money may come from third-party payments, at this time it will not be a significant amount.

Finally, with a variety of funding sources promised, the staff members assigned to the program begin preparations for program operation. They assess their education needs and inquire about in-service training from the local NCA affiliate. They begin to develop a resource library with materials about and for use with children of alcoholics and plan to visit local caregivers working with children of alcoholics to learn of their experiences. Staff members make appointments to talk with school principals about outreach education efforts in the schools. Visits are also made to other service agencies to inform other caregivers of the potential for referral in the new services. In their own agencies, staff members performing intake procedures are now informing parents of the new services and soliciting the involvement of their children.

Summary

This chapter has discussed serving the children of alcoholics from an agency's perspective. It has emphasized treatment agencies, because children of alcoholics come into contact with these agencies for many of the symptoms of family alcoholism. Yet, treatment agencies have traditionally overlooked children as their primary clients.

Recently, treatment settings have been expanding their services. New advocates for children and new specialists--educators, social workers, and art therapists--are spearheading efforts to provide separate and unique services for children of alcoholics. This chapter has shown that children of alcoholics can be a casefinding resource for an agency with the appropriate staff and facilities.

Treating the child of an alcoholic as the primary client may affect the agency's view of itself, its professional and volunteer staff training and responsibilities, its funding sources, and its hours of operation. These factors can be barriers to serving children of alcoholics. However, many agencies have found ways to overcome these problems with carefully planned intake, documentation, and referral procedures.

Mr. Wilson's concerns for his children and Steve Lawrence's conscientious behavior were the impetus for an agency to adapt to the needs of its clients. The concern had been prevalent throughout the clientele of the agency for some time, however. The important issue is that, if agencies wait for a certain level of demand before initiating service, many children of their clients may go without the help they need.

Chapter IV

The Role of Cultural Issues in Service Delivery to Children of Alcoholic Families

The Southern Community Mental Health Center in Texas has a mandate to serve several communities. Its client population includes a range of ethnic groups. After attending a regional conference on reaching minority clients, the director of the Center decides to hire a minority consultant. The consultant's job will be to develop contacts within these diverse groups, publicize the Center's services, and train Center staff in effective service delivery.

At the first training session, the staff members have an opportunity to describe how well they think the Center is serving its clientele. One alcoholism professional objects to the training. "I don't think we should put so much effort into reaching these people. They come in one time during a family crisis. They expect us to solve all their problems immediately. After investing a good amount of time in intake interviews and scheduling appointments, we never see them again. I think it's a waste of time to be concerned about these clients who won't be responsible for their own health."

The consultant responds, "You have made an important contribution to this session. We know that minority clients interrupt their treatment more frequently than other clients. They have a lower 'rate of return' for treatment, as it were. If they are not showing up for their first clinical session, there must be something happening in that intake interview to discourage them. Let's take a look at what information is exchanged and how it is exchanged during that initial contact with the agency. For example, how did you talk about alcoholism? How did you refer to the client's family involvement in the treatment plan? Being sensitive to each client's view of alcoholism, self, and family may yield greater success in keeping the client in treatment. That is what we are here to discuss."

Focus Questions

What are the cultural issues affecting service delivery?

How does the existing health system meet the needs of a variety of clients?

Are unique culturally based programs required?

Introduction

Throughout this review, it has been emphasized that children of alcoholics learn certain attitudes and values concerning family, themselves, and alcohol through the interaction in their families. The purpose of this chapter is to explain how cultural patterns of behavior learned by alcoholic families through interaction in cultural communities affect the different ways they seek and respond to service delivery. The caregiver concerned with the children of alcoholic families needs to understand family and cultural issues before intervening with or treating the child. Strategies of education and treatment depend on such understanding. Therefore, this chapter reviews some of the understanding provided by present and past research in the following areas:

- What function does alcohol serve in the cultural group?
- How does the cultural group regard alcoholism?
- What role do the members of the family and cultural community play in the treatment or prevention of alcoholism?

Each of these areas will be addressed for Native Americans, Hispanic Americans, and black Americans.

Little comparative cultural information on children of alcoholics was found. Therefore, the following discussion is focused broadly on the family and cultural group. Where appropriate, information specifically relevant to the children is emphasized.

What Are the Cultural Issues Affecting Service Delivery?

Native Americans

What function does alcohol serve? Many theories exist concerning the function of alcohol in the Native American culture. Some theories are based on observations of different tribes by anthropologists and sociologists. Others are based on the experiences of nonnative health providers and law enforcement officials who come into contact with alcohol abusers. What is important to remember is that there are "482 different and separate tribes recognized by the Federal Government" (NIDA 1977) in the United States whose members are in urban and rural settings (NIAAA 1980a). Each tribe has a unique history of development of cultural patterns and interaction with Spanish, French, and English settlers and explorers of this country. The evolution of patterns of alcohol use is a part of this history.

A review by Waddell and Everett (1980) of four anthropological studies of southwest Indian tribes highlights the historical variation in alcohol use. Some Native American groups incorporated alcohol use in hunting and agricultural rituals and in social events long before Europeans introduced alcohol as a trading medium in the 16th and 17th centuries. Other Indian groups claim external forces--for example, the development of settlements and urban bars near reservations--were responsible for the use of alcohol by their members. When some Indian leaders expressed concern that alcohol abuse would become a major problem for their people, Congress prohibited liquor sales to and among the Indians in 1832 (NIAAA 1980a). This legislation was not repealed until 1953. Even today, there are more reservations where this prohibition remains the rule than reservations where liquor sales are allowed, although bootlegging is a substantial problem on most "dry" reservations (Will Foster, personal communication, March 1982).

Native Americans face unique life decisions among the minorities living in the United States. Cultural behaviors are integral to life within an Indian tribe. As a result, leaving the tribal community often involves accepting the values and behavior patterns of other cultures. Decisions about where to work and where to establish homes bring many Indian peoples face to face with unemployment and discrimination, whether the choice is between the isolation of living on a reservation or in an Anglo community. The need to cope with the unpredictable way of life, the need to become acculturated to other non-Indian life styles, and the need to experience shared frustration have been identified as factors supporting a pattern of heavy drinking behavior.

Conflict over life decisions leads to the difficulty many Indian peoples experience in maintaining ties with their own tribes or developing new ones with Anglo communities. The development of ties in a community through participation and achievement of socially desirable goals is called developing a "stake." Ferguson (1976) identifies the low degree of "stake" development in Indian and Anglo communities as an explanation of heavy drinking, the recognition of which is a factor in successful alcoholism treatment programs. In an analysis of an alcoholism treatment program for a group of Navajo Indians arrested for drunkenness, Ferguson found that those with steady employment, homeownership, and involvement in both Indian and Anglo communities had the highest treatment success rate.

In many Indian groups drinking performs the function of binding social groups of peers. Drinking behavior is learned in social situations with one's peer group. Drinking groups often appear to be formed along age lines, that is, older men drink together and young men drink together. According to anthropological studies, these age groups may have different perspectives on the purpose and style of their drinking. The older group is more tranquil; the younger is more aggressive and boisterous, using drinking to support risk-taking behavior (Waddell and Everett 1980). In some Indian groups (e.g., Navajos and Papagos) there is a great deal of verbal pressure to convince abstainers to join in. One form of verbal pressure is the claim that drinking is identified with what is Indian. Even if people cannot afford to contribute alcohol or money, they are welcomed and encouraged to drink when the occasion arises (Escalante 1980; Waddell and Everett 1980).

Indian groups have established norms to distinguish between appropriate and inappropriate heavy drinking patterns. The primary distinction concerns group versus solitary drinking and the effect of each on family members. Drinking with one's peers and during particular events is accepted. Therefore, as long as one's drinking behavior is consistent with the values of the tribe, it is not considered alcohol abuse. However, drinking that is solitary and "selfish," lacking regard for one's peers and one's family obligations, is cause for concern.

How does the cultural group regard alcoholism? Tribal use of alcohol and culturally acceptable drinking behaviors vary. However, the Native American concept of alcoholism differs from the Anglo concept on the issue of origin. Many Indian peoples regard illness as spiritual, not physical, in origin. Alcoholism is considered a disorder of the spirit, as is mental illness. In fact, some older traditional Indians perceive alcoholism to be the same thing as insanity. In this context, even violent behavior during heavy drinking is seldom penalized. The concept of alcoholism is understood to be an Anglo one.

It is difficult for an Indian to face identification as an alcoholic, as this process brings two cultural views into conflict. By identifying oneself as an alcoholic, one seems to be accepting the values of the Anglo culture. At the same time, as a Native American, self-identification as an alcoholic is regarded as admitting a wrongdoing or weakness. The condition of alcoholism is seen as a punishment by supernatural forces. Since self-identification as an alcoholic is an important step in receiving treatment, cultural aspects of alcoholism should be viewed as a crucial factor in planning service delivery approaches.

What role do the family and community play concerning the alcoholic? The role of the family in Native American life and the interaction between Indian families and neighboring communities of non-Indians are critical elements in providing services to Indian alcoholic families. Historically, the extended family has been the cultural group that handles decisionmaking, economic maintenance, and reciprocal obligations (Cooley 1980). Allegiance is owed to one's own family, and not necessarily to neighboring families or even to the tribe. Roles, values, anticipated occupations, and memberships in social groups are transmitted within one's family. Therefore, the members of one's extended family are crucial to education, development, and support in the case of illness. This cultural answer to handling problems indicates that a direct application of traditional Anglo health care programs to Indian alcoholics may not be successful.

Another factor in effective service delivery to Native Americans is the relationship of Indian groups to neighboring non-Indian communities. As non-Indian bureaucracies and service institutions have developed in urban areas and on some reservations, these institutions have become a source of new drinking behavior standards for Native Americans. Many Indian reservations are near border towns in which it is legal to drink. Many States have decriminalized public intoxication and even provide local alcoholism reception centers for the intoxicated. In these States, Indians leave the reservation to drink in town, knowing that they will be free of judicial sanctions and will have a safe place to dry out. Unfortunately, most communities that have decriminalized public intoxication consider the drinking problem to be an Indian problem alone. Therefore, there is little financial support for either alcoholism prevention, treatment programs, or cultural centers where Indians may be involved in alternative productive and stimulating social activities (Wood 1980). In States without decriminalization laws, an intoxicated Indian is often more harshly treated than an equally inebriated white resident.

Due to the lack of support from many Anglo communities, Native Americans must rely on their own resources at the tribe and family level to combat the effects of alcoholism on the alcoholic and the family. The Native American culture traditionally prescribes specialist roles for tribal members, such as healers and educators. These traditional caregivers, together with family members and Native Americans trained as alcoholism specialists, can work with the alcoholic and family to foster an understanding of the disease of alcoholism and develop prevention and treatment programs consistent with Native American philosophies of health.

Culturally based and supported prevention programs are especially important for Native American children of alcoholics (Will Foster, personal communication, March 1982; Mason 1982). According to a recent National Council on Alcoholism position paper (1980), 80 percent of Native American college students and 50 percent of high school students drop out due to family alcoholism. This is only one of the effects felt by these children.

Children in alcoholic Native American families hear conflicting messages about the use of alcohol. As a result they are confused over whether to drink and how much to drink. Children see the drinking behavior of male family members accepted. Both aggressive and recreational behaviors are associated with alcohol abuse. Parents do not bother children over the age of 18 who drink (Mason 1982). Because children of alcoholics are more likely to become alcoholics, the perpetuation of role models of alcohol abuse can only compound the Native American youth's chances of becoming an alcoholic. It is easy to see how alcohol abuse can become the number one health problem among Native Americans.

Alcohol education programs that have a principal goal of countering the cultural attitudes toward alcohol use and abuse may be the most useful response for Native American children of alcoholics (Will Foster, personal communication, March 1982). Mason (1982) recommends the school as the ideal setting to confront these attitudes. She further advises that education focused broadly on decisionmaking and coping skills would be more acceptable to children and to the school than intervention by an alcoholism specialist.

The teacher who possesses facts about alcohol use and other youth problems can work with parents, bringing them into the classroom or working with them at home, to participate in "saying no" skill development activities with their children. Ideally, these skills would provide the basis for helping youth to resist peer group pressure which might be exerted to use or abuse alcohol.

Hispanic Americans

What function does alcohol serve? There are many different nationalities of Hispanic persons living in the United States or immigrating to find employment and to join families already here. These nationalities include Mexicans, Cubans, Dominicans, Puerto Ricans, and Guatemalans. Although there has been limited research on Hispanic alcoholism and alcohol use, and virtually nothing on children of Hispanic alcoholics, what is available shows that there are differences in Spanish American populations by national origin, racial background, Spanish-speaking ability, socioeconomic level, and degree of acculturation (Sanchez-Dirks 1978). Any discussion of general Hispanic patterns of alcohol use is therefore limited, corresponding to the limited findings about different groups.

In general (Gordon 1979; Parachini 1981; Rodriguez et al. 1979; Sierra 1981; and Technical Systems Institute 1980), researchers have found that members of Hispanic populations drink heavily or not at all. When excessive drinking by either men or women prevents individuals from meeting their responsibilities, it is viewed negatively by family and community.

Definitions of acceptable and unacceptable alcohol-related behavior may vary among groups and

across locales and situations. Myths regarding cultural patterns of alcohol use are one of the targets of researchers and clinicians now working with the Hispanic alcoholic family. The goal is to identify actual patterns of alcohol use and incorporate them in elements of program development and the training of caregivers working with the family and with children.

How does the cultural group regard alcoholism? It is widely believed that the male Hispanic is regarded as head of his family and that this role is carried over to social situations. That is, the male is regarded as the authority within the family and the community. The term "machismo" refers to the male's ability to support his family and maintain its economic independence. Success in the economic sphere entitles the male to drink with friends freely. Peer groups drink together after work and during social events. If the male Hispanic has problems related to his drinking behavior, his family tends to blame the problems on fate, God's will, or a bad wife (Romero n.d.). The tendency to avoid the health issues of alcoholism may vary, however, according to the degree of acceptance of Anglo values by the Hispanic and his family.

The concept of male dominance in the Hispanic culture is being disputed (Andrade 1980). It may be that decisionmaking in the home is really dominated by the female Hispanic. However, the concern for the image of the male within his extended family and community leads to a general portrayal of the male as head of the household. This extends to an avoidance by the female and children of seeking help outside the community for problems. There is an effort to protect the image of the male even when his alcoholism may be affecting the economic life of the family.

Hispanic women are expected to fulfill the important roles of wife and mother. After they have raised their families, women attain a certain status as "mother," which allows them to be involved in their children's families. According to Romero (n.d.) the process of attaining this status involves giving up a woman's individuality for the sake of the family. This creates serious problems for the female Hispanic alcoholic.

The Hispanic woman is not supposed to embarrass her "people," which includes her husband's mother and family as well as her own. If a woman has alcohol-related problems, she receives less family support for treatment and rehabilitation than a man would (Romero n.d.; Technical Systems Institute 1980). Her problems are blamed on her lack of dedication to traditional roles. Unlike the male alcoholic, no one makes excuses for her. People advise the Hispanic woman not to stay away from her family and therefore do not encourage involvement in treatment programs that separate her from the family. As a result, although traditional Hispanic women may drink less than those who have accepted the values of the Anglo culture, those who have alcohol-related problems come into treatment later and remain for a shorter period of time.

From an analysis of a survey on drinking practices of youth, Sanchez-Dirks (1978) reports certain characteristics or patterns of drinking among Hispanic youth. No information was available for analysis on the use of alcohol by Hispanic children of alcoholics.

Hispanic youth living with both parents drink less than youth living with their fathers only. However, when asked about the effect of their parents' attitudes toward drinking on their own drinking habits, Hispanic youth said they value their friends' opinions more than their parents'. These youth also showed themselves to be higher consumers of alcohol than the youth who value their parents' opinions.

For Hispanics, the role-related patterns of alcohol use, the sex-related support for alcoholism treatment, and the denial of alcoholism as a problem requiring treatment are reinforced by a church view that alcoholism is a moral weakness. In general, these factors are responsible for the tendency of the Hispanic alcoholic family to enter treatment at a more advanced stage of alcoholism (Diaz 1982; Rodriguez et al. 1979; Sierra 1981). Gordon's study (1979) of Hispanic groups in a Northeast city and the Technical Systems Institute's study (1980) of three Hispanic communities in California both discovered a general reluctance to use the services that were available in the larger community.

Men have been the principal target group for alcoholism services, even though their families are reluctant to report alcohol-related problems to the appropriate caregivers. Gordon (1979) found that women are afraid to talk about their husbands to strangers in clinics or service institutions. To obtain help for their husbands or themselves, women are more likely to be in contact with a minister or a physician.

What role do the family and community play concerning the alcoholic? The cultural view of alcohol use and alcoholism indicates that different members of the family receive different kinds of help for alcohol-related problems from their families and from the community. Males receive more assistance from their families, who tend to attribute male alcohol abuse to external problems. Women receive little support and are directly blamed for their own alcohol abuse.

Some studies have indicated that the church's view of alcoholism as a moral weakness is a chief stumbling block in the way of outreach to Hispanic alcoholics and their families. In Gordon's study (1979) of the use of alcoholism services by Hispanics in one Northeastern United States city, Hispanics of different nationalities relied on the church as a helping institution. Both the Catholic Church and the Pentecostal Church were used by Hispanic alcoholics, although for different reasons, as supports to stop drinking. Diaz (1982) found that by working with the religious officials of the Pentecostal Church, support was developed for an education and treatment program for children of alcoholics. Once the church gave its approval to the program as consistent with its ideology, parents were willing to

allow their children to attend cultural and educational activities at a youth center established in the church.

In general, research has found that Hispanics use intermediary indigenous or local services and institutions for help before going to traditional caregiver institutions. Certain characteristics of the indigenous institutions, such as ascribing respect and dignity to the male and maintaining a balance between the formality and informality of staff interactions with the Hispanic family, are cited as factors affecting this choice (Aguirrez, personal communication, March 1982; Rodriguez et al. 1979).

The family's refusal to consider itself as a client has affected the delivery of services to Hispanic children of alcoholics. Children receive mixed messages about treatment according to the sex of the alcoholic parent. Since the family does not typically enter treatment together, children are not involved in the rehabilitation process.

Hispanic children of alcoholics, like children of other cultural groups, need educational experiences that focus on the conflicts within their culture concerning alcohol use and alcoholism. This may be one way to educate parents and the extended family about the needs of the alcoholic as well. Culturally identifiable programs with bilingual staff may be the most successful way to reach the family as a whole. Although Hispanic professionals disagree about whether treating the whole family is a realistic goal, most agree that if the family is involved at some time, it will be beneficial for the recovery of the alcoholic member.

Black Americans

What function does alcohol serve? Before black Africans were brought to the United States to work as servants and then as slaves, alcohol use was related to tribal and family celebrations and ceremonies. Many tribes made their own wine from vegetation that they cultivated. Although drinking was heavy during these ceremonial situations, behavior norms were established and alcohol use was not permitted to interfere with work. A great deal of social pressure was brought to bear on group members who abused drinking opportunities and were unable to fulfill their roles as workers and providers for their families.

As servants and slaves in the United States, blacks were subject to control and restriction, including control of their use of alcohol. Different perspectives are expressed by black researchers on the participation of blacks in this control system. Some believe that slave owners gave alcohol to their slaves on holidays to control their behavior, keep them from running away, and keep them happy. Others believe that blacks were resourceful in convincing owners to provide this opportunity to socialize. This latter view holds that blacks created an innovative lifestyle for themselves that integrated their African heritage with an American one, combining music, dance, and drinking (Caldwell 1981).

During the Civil War and Reconstruction periods, blacks in Southern States were restricted from possessing both firearms and alcohol. The fear that alcohol use would lead to uncontrolled revolt stemmed from concerns after the Nat Turner rebellion in 1830 (NIAAA 1981d). These restrictions remained in effect after slaves won their freedom following the Civil War.

The migration of blacks to other areas in the United States to find work after the war resulted in the development of different drinking patterns. Away from their families, lacking money, and needing mutual support, blacks settled in the same areas, usually in poor housing that was readily available. Especially in the summer, people congregated outside to keep cool and to maintain friendships. Taverns fulfilled these social needs in the winter months. Drinking was a daily pastime for meeting friends and unwinding from jobs. On weekends, groups of friends drank outside of and inside taverns and on corners near their neighborhood stores and homes.

This pattern of group drinking continues among some socioeconomic groups, such as blue-collar workers and street people. Alcohol is used to stimulate conversation and social relationships. In general, blacks have been status-conscious drinkers, buying the more expensive name brands of liquor to impress their friends (Harper 1976; NIAAA 1981d).

How does the cultural group regard alcoholism? In the black community alcoholism has been generally regarded as a moral weakness. This perspective stems from a cultural acceptance of certain intoxicated persons as permanent and less moral "characters" in the community, especially by the black churches. The church is a reference for moral standards and is often the center of family activities. Although the Protestant Church does not promote abstinence, it views alcoholism as a moral weakness that can be overcome by strengthened religious faith and activity. Some blacks belong to the Black Muslim religion which does require abstinence.

The view of alcoholism as a moral problem has prevented many black alcoholic families from seeking professional help. However, Wright (1981) reports that, once in treatment, black clients maintain their commitment to complete it.

Wheeler (1977) has identified other cultural issues affecting the black perspective on alcoholism. As a minority group in American society, blacks have frequently had to solve their own problems through the resources of their extended families or communities. Therefore, when drinking behavior interferes with family and work responsibilities, black families have turned to community networks of churches and social clubs for assistance. Some blacks perceive people who do seek the help of counselors as "sick." They are reluctant to use, and are less knowledgeable about, the services of psychology and psychiatry. This reluctance may also stem from the limited availability of culturally sensitive sources of treatment. Issues of confidentiality observed by members of these professions are also of great concern.

Harper (1976) reports that lack of knowledge about alcoholism and existing services in the black community partly reflects the lack of interest in alcoholism on the part of black leaders. These leaders have always focused on bringing issues of economic and social discrimination against blacks to the forefront of public discussion. Christmas (1978) observes that a similar preoccupation with living conditions has prevented chronic drinkers from identifying their own alcoholism as the problem. Even when rehabilitated through community detoxification programs, chronic drinkers do not demonstrate an interest to improve. They see the same conditions of life remaining in their community and they blame these conditions for their heavy drinking.

What roles do the family and community play concerning the alcoholic? Considering the cultural history of relying on family and community resources, these two human institutions should be an important part of any strategy to work with the black alcoholic. Blacks have not been consistent users of the existing social and health systems established by the white culture. Black researchers attribute this to inherent barriers of discrimination and insensitivity within these bureaucratic institutions.

Alcoholism specialists who have worked in the black community recommend that the alcoholic family would best be served by a comprehensive service program. Such a program would meet the variety of economic, social, and health needs of the family members. If all family members were participants in various programs at the same location, treatment of the whole family for the alcohol-related problems of one of its members could be coordinated within the service institution.

Black youths encounter stereotypical images of black alcoholics in the media and in daily community life. Researchers who assume that black youths are likely substance abusers compound the difficulty of combatting these images. Many black youths do not abuse alcohol or drugs. A more positive approach to involving black families in prevention and treatment programs is advocated by Crisp (1980).

Black children of alcoholics must confront the denial of alcoholism as a health problem and the negative self-image perpetuated in their own and majority communities. Crisp (1980) and Ortiz (1980) recommend developing education and prevention programs that first focus on the systemic problems of racism, sexism, power, and economic differences. Because many blacks see these problems as sources of frustration contributing to alcoholism, program developers identify a systemic focus as most effective in outreach efforts.

How Does the Existing Health System Meet the Needs of a Variety of Clients?

According to a report on mental health services for rural minorities (MITRE Corporation 1981) and the articles by Christmas (1978), Davis (n.d.), and Harper (1976), the existing health service system of mental health centers, clinics, hospitals, and private treatment settings has a poor record of service for the minority client. Christmas reports that programs have been generally geared to the middle-aged, white male alcoholic who is recently employed and is at a low socioeconomic level. Historically, Federal assistance in the development of alcoholism treatment programs has gone primarily to Native Americans (Christmas 1978). Black treatment programs were supported originally through the Office of Economic Opportunity, when the prevailing theory held that economic and social discrimination were the cause of alcoholism in the black community. In the past decade, local affiliates have begun outreach efforts to minority communities. NIAAA has supported these efforts through materials developed by the National Center on Alcohol Education, the National Clearinghouse for Alcohol Information, and technical assistance for workshops.

Native Americans

At least through 1973, American Indian alcoholics were typically involved in three kinds of treatment programs: Alcoholics Anonymous; psychotherapy and psychiatry; and large-scale therapy with disulfiram, a drug creating a physical reaction to alcohol (Shore and Von Fumetti 1972). These programs were established for the most part by non-Indians through the Office of Economic Opportunity and the Indian Health Service of the U.S. Public Health Service. All the authors reviewed here assert that programs should be developed and run by Indian tribal councils, that Indians should be recruited as staff, and that a program's philosophy of health should reflect the specific Indian group's definition of mental health. This policy has been adhered to by NIAAA in large-scale funding of Indian programs from 1973 to 1981.

Disparity between Anglo and Indian philosophies of alcoholism and treatment and mistakes in staff training and assignment of responsibilities have hindered Native American program success in the past. These mistakes include hiring Indians just to give them jobs, hiring Indians believing that "Indianness" in itself is adequately therapeutic, and neglecting the training of Indian staff in the medical model and disease concept of alcoholism.

According to Miller and Ostendorf (1980), training of Indian counselors is well within the tradition of native healers and should not be slighted. To fulfill traditional roles in their tribes, native practitioners must undergo an apprenticeship and demonstrate their competence to their people. Miller and Ostendorf (1980) recommend that in Anglo-sponsored health programs, Indian staff be hired who are stable, who "have a good heart," and who will not let family and tribal problems interfere with objective counseling. Although Indians are not happy to be supervised by those from their own tribe, they will accept help more readily from Indians than from non-Indians.

Training should pay particular attention to the development of counseling skills. The confessional

aspect of many counseling sessions of AA meetings is not consistent with Indian values of keeping personal information confidential or within one's family. Indian staff members must be able to convince their clients that confidentiality will be maintained even in these methods of treatment. Indian counselors trained in proven Anglo health strategies will be able to explain what may seem like alien principles to their clients.

An important factor in program success is its perspective on the dimension of time. Indians value adequate time to make decisions and changes. In an Anglo treatment program, this may be frustrating for the administrators and staff. A nontraditional scheduling approach is required to meet the needs of Indian clients. Hiring Indian counselors who understand this is one way to alleviate this potential source of tension (Wood 1980; Miller and Ostendorf 1980).

Family involvement in treatment must be approached cautiously. Males, who make up the largest percentage of alcoholics being treated in Indian programs, may not wish to talk about their lack of control of drinking in front of their wives and children. This factor may also affect the choice of a counselor assigned to work with the male alcoholic. Most prefer to talk with male peers as is consistent with the culturally valued social group experiences in which they learned to drink. In fact, recovered male alcoholic Indians have composed the staffs of most Indian alcoholism treatment programs until recently. As younger males and females are being educated in training programs like the one at the University of Utah and then hired by treatment programs, these older men have returned to other vocational opportunities on the reservation and in neighboring urban communities.

In a review of literature on Native Americans and alcoholism, Weibel (NIAAA 1977) notes the lack of existing information on Native American women and alcoholism. Weibel reports reviewing more than 400 citations compiled in 1977 concerning alcoholism among Native Americans, not one of which specifically addressed the issues relevant to Native American women.

Some effects of alcoholism on Native American women have been reported, namely, (1) a high rate of fetal alcohol syndrome; (2) the high rate of cirrhosis deaths accounted for by females among Indians, almost half the total number of cirrhosis deaths; and (3) the neglect of children in alcoholic families (Ackerman 1971; Malin et al. 1978; Streissguth 1978). Differential drinking rates and rates of alcohol abuse have been noted by Weibel and Weisner (1980). The lack of research on drinking rates and the effects of alcoholism on women and their children has been deplored by Malin et al. (1978) and Leland (1978, 1980).

As do all counselors in the alcoholism field, Native American counselors receive a great deal of pressure from insurance companies and professional associations to obtain advanced training and degrees. This pressure is felt strongly by Indian counselors in Anglo urban alcoholism programs serving Indians. For the most part, programs on the reservation serve people who do not carry health insurance; therefore, counselors working there are not as concerned with this credentialing movement (Wood 1980).

Tribal council control of alcoholism programs can ensure the participation of the whole community in the mental health of its members. The establishment of nondrinking reference groups, the scheduling of drinking hours at Indian pubs, and the development of rules governing intoxicated pub customers and transportation of beer out of the pubs would demonstrate the tribe's ability to take action and combat the image of powerlessness and dependency that has stereotyped Native American people.

One example of an innovative response by a community to a concern for alcohol abuse is reported by Steinbring (1980) among the Saulteaux in Manitoba. When urban expansion brought easy access to alcohol, the community established AA as a symbol of unity against alcohol abuse. Membership in AA was a respected tradition; chapters were extensions of one's family group. Competition between chapters was active. Anonymity was given up to express pride in membership.

In this case a tribe applied Indian principles of family obligations to an Anglo treatment method. Researchers working with Native Americans are still divided over which treatment and prevention strategies work best. Indians who are accultured do very well in Anglo programs. For others, programs which incorporate Indian concepts of mental health seem more realistic. At the present time, defining the program goals with the Indian group designated as the target population, staffing and training it with Indian counselors, and institutionalizing it within the tribe are measures recommended by health providers working with Indian alcoholics.

Hispanic Americans

In general, the denial of alcohol problems by both Hispanics and service providers and the reluctance to use formal services for assistance result in an underutilization of human and health services by Hispanics. A majority of Hispanics do not consider alcoholism as a problem requiring treatment (Technical Systems Institute 1980). The Hispanic alcoholic is generally identified upon presentation to traditional social and health institutions for treatment of alcohol-related medical, social, or economic problems.

Gordon (1979) found that these institutions lack consideration of cultural patterns of family interaction and alcohol use. Therefore, Hispanic women, the most likely group to present themselves and their families for assistance, are reluctant to use these traditional services. Women and children are the chief clients of community-based health centers. If community people are employed as aides and intake personnel, Gordon found that women are more willing to confide alcohol-related problems.

In a review of the use of service institutions in three California locales, Technical Systems Institute (1980) found that a lack of communication between

alcoholism and nonalcoholism agencies may have affected underutilization of services by Hispanics. Alcoholism service providers did not seem aware of other locally available services. Similarly, nonalcoholism services were not actively referring people to alcoholism services. Very few service providers directed their programs to Spanish-speaking subpopulations.

Black Americans

Wright (1981) reviewed the research literature on counseling blacks and found that it emphasizes an image of blacks as poor clients. Counseling the black client has been considered by many professionals to be counseling the culturally deprived. This notion was institutionalized by policymakers at the Federal and local levels through the use of terms such as "socially and culturally deprived" and "disadvantaged." Unfortunately, the stereotypes transmitted about the black client have prevented a genuine effort to understand the cultural differences inhibiting blacks from effectively using the existing services.

The structure and setting of alcoholism services are also factors in their underuse by blacks (Wright 1981). Alcoholism services are traditionally not located within or near black communities. Blacks developed a pattern of choosing other alternatives to deal with their problems rather than trying to reach these and other medical and social services. When access to alcoholism programs was available, blacks found the structure and services limited. The treatment in these programs was therapeutic and focused on changing alcoholic behavior. Since blacks viewed other life circumstances as contributing factors in alcohol abuse, they preferred assistance for employment, housing, and nutrition needs. The lack of availability of these services and the lack of concern by those running the programs made participation in any other alcoholism services seem useless.

Another institutional barrier to the use of existing health services was the discrimination practiced by insurance companies. Insurance companies set rates based on actuarial tables indicating that blacks had a higher mortality rate than whites. Therefore, blacks were charged higher premiums. Of course, these policies made a difficult situation even worse. Traditionally, many blacks have been employed in jobs which do not provide health insurance and will not support individual purchases of policies. With increased costs incurred because of insurance projections, blacks were effectively discouraged from using services funded by third-party payments. A series of laws in 1935, 1943, and 1964 prohibited discrimination in insurance commission payments and premium charges and in writing, rating, or underwriting insurance policies.

Although the Office of Economic Opportunity supported the poverty alcoholism programs in the 1970s, black researchers report that services and trained alcoholism staff working in the black community are still inadequate. Black programs have problems in recruiting experienced and culturally sensitive staff and in becoming credentialed, as do other community-based programs for Native Americans and Hispanics. The recent formation of the National Black Alcoholism Council should give this cultural group a voice in State and Federal policies concerning prevention and treatment programs. Programs at Jackson State and Meharry Medical College provide opportunities to train black alcoholism professionals. The process of developing services to meet the needs of black alcoholics proceeds slowly. Meanwhile, practitioners advise the use of local community groups to publicize services, provide access to and information about insurance, and focus prevention efforts at young blacks still in the community.

Summary

This review of cultural issues affecting service delivery has emphasized that cultural groups have histories of alcohol use that may or may not have an effect on the development of alcoholism in any one individual. However, the history and ways of responding to alcoholism do affect an alcoholic family's use of available health services.

There has been a poor service record in the delivery of services to meet the needs of cultural groups. Factors operating in this poor record are related to: (1) the structure of the service organization, (2) its staffing patterns, (3) its setting in relationship to the communities it serves, and (4) the attitudes toward alcoholism and health assistance held by the clients themselves. The following section examines these factors as professionals in the alcoholism field have analyzed them, in the hope of encouraging minority clients to use available services.

Staffing, Structure, and Setting of the Service

The practitioners reviewed here emphasize that to be successful in reaching diverse groups of clients, a program -- whether educational or therapeutic -- should include bilingual/bicultural staff and staff who have been trained to be sensitive to the needs of individual clients. Discriminatory hiring practices, the credentialing process, and the lack of specific training in minority health issues are cited as the crucial problems in hiring and retaining minority caregivers in professional positions.

In the alcoholism field there seem to be two perspectives on the staffing issue. Some practitioners argue that they cannot find certified minority caregivers to hire for their programs. A negative expectation seems to create a self-fulfilling prophecy; that is, very few minority caregivers are hired for professional roles, as opposed to nonprofessional and paraprofessional ones. As a result, minorities are less visible on the staff and their impact on the communities served is lessened considerably.

The other view is that the credentialing process supported by professional associations and insurance

companies discriminates against the minority caregiver. Minorities argue that when treatment programs directed to minorities were first conceived, recovered alcoholics were hired to serve in professional roles. Community members recruited in the poverty alcoholism programs and in Indian reservation-based programs experimented with different outreach and treatment strategies that traditional agencies could not afford. Although nondegreed, these caregivers were providing the same services as specialists. When third-party payments became a critical funding source, insurance companies insisted on credentialed staff. Professionals graduating from degree programs joined in support of the establishment of national standards for alcoholism counselors and other caregivers.

As nondegreed caregivers try to attain these standards, they find their experience is discounted. They are required to enroll in summer alcoholism institutes or in university programs. Many find this too expensive and argue for credentials based on years and types of experience. Others recommend that insurance providers should be included on credentialing boards. The expectation is that an understanding of the job requirements and the overlapping job descriptions in alcoholism programs will lead to a more precise determination of the knowledge and skills required of different caregivers in a credentialed program.

All the researchers and practitioners cited in this chapter agree, however, that merely hiring minorities will not ensure effective service delivery to diverse groups of clients. Technical knowledge and sensitivity to cultural differences may be developed through training in specific courses in both summer institutes and university-sponsored inservice courses within agencies. Christmas (1978) recommends that staff at all levels understand the various blocks to accessing health systems, how individuals from different cultures perceive assistance from an institution, how different communication styles affect clinical experiences, and that negative experiences with bureaucracies are a part of almost all minority clients' past efforts to obtain health and social services.

Representation on boards of directors or advisory boards of diverse client groups is another important strategy to encourage usage by minority clients. Whether the setting is a community mental health center required to incorporate the views and needs of the communities it serves, a private hospital, or a social service agency, involvement in the policy-making of programs serves at least two purposes. By identifying and electing representatives of respected and powerful social and cultural groups within communities, community members are assured a voice in the policy decisions of the service agency. At the same time, minority board members take the message of service opportunities from the agency to their communities. Community members respect their leaders' involvement and are more likely to use the services on their recommendation. Hiring minority consultants and working with informal social networks such as churches and social clubs are two additional methods to disseminate service information and involve community members in service delivery.

The setting of a service agency can be a barrier to effective usage. Typically, the clients using social service agencies and clinics have less flexibility of time because of the kinds of jobs they hold and their job locations. Therefore, the establishment of a program in a work setting or within a minority community is more likely to encourage its use. The hours of the program operation and the flexibility of the staff are key components in a plan to encourage usage. In addition, linkages of staff, services, or locations of services with other agencies and hospitals will provide necessary support services for the clients and decrease the cost to one service agency of being all things to all clients. This is especially important when serving individuals who hold jobs without insurance benefits or who are unemployed.

Client Knowledge and Attitudes

Given the most supportive program and staff possible, the knowledge and attitudes of the clients are the motivating force in using available services. All the researchers and practitioners reviewed in this chapter have indicated that the clients' knowledge about alcohol and alcoholism, concern about the use of services outside the family and religious group, concern about payment for services, and identification of other problems as more serious prevent them from using alcoholism services.

Some cultural groups do not accept alcoholism as an illness and therefore do not view health services as an antidote to drinking. When alcoholism precipitates a crisis within the family, a loss of economic stability, a life-threatening situation, or trouble with the children, these clients are likely to turn to an institution or agency for help. At this point, the client is uninformed about payments or eligibility for financial assistance. The administrative procedures essential to the management of the agency are threatening and discourage clients from coming back and establishing a continuing, preventive relationship with the agency.

For those clients making a commitment to use services, a realization that the goals and strategies of a program conflict with their cultural views on family roles and religious beliefs may cause an interruption in program participation. Culturally recognizable caregivers and strategies, as indicated earlier, are essential to reassure clients that their perspectives are being incorporated in the program.

Most practitioners argue that community control of programs is the best strategy to ensure community use. The problems resulting from the community control perspective are related to the priorities held by the community and by local and State governments providing funding. Many cultural group leaders view unemployment as the cause of unrest and alcoholism. They are not interested in alcoholism programs focusing exclusively on the disease of alcoholism and would rather see a program established to deal with all the socioeconomic issues faced by community members, such as providing job

training for recovered alcoholics as well as counseling for their families. They also view alcoholism and other mental health problems as employment opportunities for community members.

With anticipated changes in the support of community programs, communities must examine their health and social needs and become involved in policymaking about social and health services.

Most prevention and treatment programs are developed, managed, and staffed by the nonindigenous culture. As a result, the values and attitudes figuring in an indigenous culture's response to alcoholism are generally not integrated into procedures and strategies. This may prevent people who most need the services from using what is available. Service institutions can alleviate the blocks to service use by the following strategies:

- Develop a program philosophy and goals with representatives of the client populations.
- Hire and train (both by inservice programs and by supporting enrollment in degree programs) staff from the client populations.
- Maintain documentation and evaluation systems to determine how well services are fulfilling community needs.
- Recruit community representatives for positions on advisory boards.
- Link services to community organizations and other service agencies.

Gaps in Services to Cultural Groups

Researchers and practitioners concerned with delivery of services to alcoholic families of different cultures have made recommendations concerning filling the gaps in research, training of caregivers, and service programs.

The literature about alcoholics of different cultural groups reveals a lack of information on prevalence rates of alcoholism among subpopulations, family drinking patterns, and reasons for underutilization of existing services. Andrade (1980) and other researchers recommend that ethnic researchers be trained to conduct this work within their respective cultural groups.

A major concern of the authors reviewed in this chapter is for the training of alcoholism workers in bilingual/bicultural issues. The authors comment that, depending upon the degree of acceptance of the values of the majority culture among cultural groups, same-culture and different-culture caregivers are needed. Therefore, there has been an effort to develop materials for training both ethnic caregivers and majority culture caregivers to be aware of different perspectives held by caregivers and clients, and to be sensitive to the cultural identities of their clients. Some of these materials, such as the Cultural Family Assessment by Moore and Andrew and the Cultural and Ethnic Assessment Instruments by Silva, examine the cultural roles ascribed to individuals within a family and the issues they present for program planning. These culturally relevant materials have been developed chiefly for Hispanics and Native Americans. However, their principles of culture conflict and cultural identity assessment can be applied to any cultural group.

The lack of culturally specific programs is the major gap in delivery of services to cultural groups. This is especially true for children of alcoholics. A number of prevention/outreach programs have been established in minority communities to reach children and prevent them from using drugs or alcohol. However, Crisp (1980) and Ortiz (1980) maintain that many of these programs disregard the systemic issues that minorities see as the cause of their substance abuse problems. It does seem important to consider the problems of a community or cultural group as the starting point for program development, rather than imposing a particular model on all communities.

Each cultural group discussed in this chapter has particular needs to consider in the development of programs and training materials for caregivers. In general, not seeing alcoholism as a disease keeps many people from seeking help. This may actually be encouraged by religious beliefs, family customs, and cultural norms concerning handling the alcohol-related problems that would ordinarily bring families into contact with alcoholism specialists.

Cultural differences affect children of alcoholics in the following ways. Children receive mixed messages about the appropriate use of alcohol and about the recognition of alcoholism as a problem. They see men and women with alcohol problems treated differently in their families. This adds to confusion over understanding the illness of the alcoholic parent and compounds the problems generally associated with being a child of an alcoholic. There is little support for understanding these feelings and no support for getting help to deal with them.

In the vignette at the beginning of this chapter, the Southern Community Mental Health Center is making an effort to eliminate barriers to service delivery by hiring a minority consultant. While being responsive to the client populations they expect to serve, the staff at this Center can also turn their attention to the children of these families.

All the information reported in this chapter indicates that children in the cultural groups addressed are prime audiences for prevention and education programs.

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Steinglass, P. A life history model of the alcoholic family. Family Process 19 (3): September 1980.
Streissguth, A. "Fetal Alcohol Syndrome." Paper presented at the Second Annual Alcohol Abuse Conference, University of California, Berkeley, 1978.
Technical Systems Institute. Final Report on Drinking Practices and Alcohol-Related Problems of Spanish-Speaking Persons in Three California Locales. April 25, 1980.
Triplett, J.L., and Arneson, S.W. Children of alcoholic parents: A neglected issue. Journal of School Health December 1978.
Waddell, J., and Everett, M. Drinking Behavior Among Southwestern Indians. Tucson: University of Arizona Press, 1980.
Wegscheider, S. From the family trap to family freedom. Alcoholism 1(3): 36-39, 1981.
Weibel, J.C., and Weisner, T. The Ethnography of Urban and Rural Indian Drinking Practices in California: Annual Report to the Department of Alcohol and Drug Abuse Programs, Sacramento, 1980.
Weir, W.R. Counseling youth whose parents are alcoholic: A means to an end as well as an end in itself. Journal of Alcohol Education 16(1):13-19, 1970.
Wheeler, W. Counseling From a Cultural Perspective. Atlanta, Ga.: A.L. Nellum and Associates, 1977.
Whitfield, C. Children of alcoholics: Treatment issues. Maryland State Medical Journal pp. 86-91, June 1980.
Wilson, C., and Orford, J. Children of alcoholics: Report of a preliminary study and comments on the literature. Journal of Studies on Alcohol 39:121-142, 1978.

Woititz, J. "Adult Children of Alcoholics." Paper presented at the National Council on Alcoholism Annual Forum, New Orleans, April 1981.
Wolin, S.; Bennett, L.A.; Noonan, D.L.; and Teitelbaum, M.A. Disrupted family rituals. Journal of Studies on Alcohol 41 (3):199-214, 1980.
Wolin, S.; Steinglass, P.; Sendroff, P.; Davis, D.; and Berenson, D. Marital interaction during experimental intoxication and the relationship to family history. In: Gross, M.M., ed. Alcohol Intoxication and Withdrawal. New York: Plenum, 1975.
Wood, R. Urban alcoholism. In: Waddell, J., and Everett, M., eds. Drinking Behavior Among Southwestern Indians. Tucson: University of Arizona Press, 1980. pp. 217-221.
Wright, E.J. "Counseling from a Cultural Perspective." Paper presented at an NIAAA Workshop. Rockville, Md.: National Institute on Alcohol Abuse and Alcoholism, 1981.

Appendix A
A Reading List on Children of Alcoholics

The following is an annotated reading list on the topic Sons and Daughters of Alcoholics. Publications and materials have been selected to aid both the professional and the layperson interested in current information regarding this subject. This list is not intended to be an exhaustive bibliography. Selected materials cover such topics as family interactions and personality characteristics; prevention, intervention, and treatment; family violence, child abuse and neglect; and fetal alcohol syndrome and genetic vulnerability.

Following the abstract for each selection is a notation giving the availability and cost of the item. Prices are subject to change.

Alcoholism/The National Magazine 1(3):1981. Family focus issue features the following articles on children of alcoholics:

Black, C. Innocent bystanders at risk: The children of alcoholics, pp. 22-26.

The author contends that it is of immediate urgency that all helping professionals identify children of alcoholics and begin preventive work immediately. Ways these children can be identified, some of their typical behavior, and some of the emotional and even physical abuse they suffer are explained. The dynamics of the family are discussed, and three main roles (the responsible one, the adjuster, and the placater) found to be more characteristic of children in alcoholic homes are described.

Dulfano, C. Recovery: Rebuilding the family, pp. 33-39.

The author contends that in today's increasingly fragmented society, the social group that bears the most responsibility for producing autonomous but connected individuals is the nuclear family; i.e., the family's task is to support individual growth and development and provide stability (while changing to adapt to individual and cultural demands). A profile of a family in which both the husband and wife have drinking problems is presented to illustrate the effectiveness of therapy in rebuilding the family structure. It is shown how the husband and wife were helped individually through Alcoholics Anonymous, and together as spouses and parents through family involvement.

Availability: Alcoholism/The National Magazine
P.O. Box C19051
Queen Anne Station
Seattle, WA 98109
($5.00 an issue)

Altman, M., and Crocker, R., eds. Social Groupwork and Alcoholism. New York: Haworth Press, 1982. This book contains the following articles on the topic of "children of alcoholics":

Brown, K.-A., and Sunshine, J. Group treatment of children from alcoholic families.

A play-therapy group for the latency-age children of alcoholic parents is described, and the authors discuss the effects of parental alcoholism on children's development during latency. Children from alcoholic families constitute a vulnerable population whose lives can be changed through appropriate intervention. Alcoholism often damages family relationships, and the group therapy described here provides an opportunity to repair them. It is stated that through participation in groups, children can learn to put the familial alcoholism into perspective, find ways to cope with it, and achieve satisfaction in life.

Deckman, J., and Downs, B. Group treatment approach for adolescent children of alcoholic parents.

According to research data, children of alcoholic parents are twice as likely to become alcoholic as are children of nonalcoholic parents. Also, some children with alcoholic parents have significant emotional and behavior problems. The authors describe a group counseling treatment modality for adolescent children of alcoholic parents. The objective of the group is to help those children who have feelings of helplessness and isolation before they become fully mature. Results and common themes of the group experience are discussed.

Availability: The Haworth Press, Inc.
28 East 22nd Street
New York, NY 10010
($16.00)

Black, C. It Will Never Happen to Me! Denver: M.A.C., 1981.

In this book, the author discusses the experiences of children of alcoholics--as youngsters, adolescents, and adults. In addition, the process of what happens and what can be done to prevent and handle the problems these individuals may face is discussed. Identifying roles, problems children have within the home, family violence, and information about where to turn for help are other areas covered in this book.

Availability: M.A.C.
Printing and Publications Division
1850 High Street
Denver, CO 80218
($7.95)

Cermak, T.L., and Brown, S. International group therapy with the adult children of alcoholics. International Journal of Group Psychotherapy 32(3):375-389, 1982.

In line with the systems model of alcoholism, the Stanford Alcohol Clinic (California) has been treating alcoholics in group and family settings, as well as using the more traditional individual approach. As a result of success with this new mode of treatment, a dynamic interactional group for the adult children of alcoholics was instituted with a small number of patients. Preliminary results are reported here, and include the observation of conflicts concerning issues of control, trust, personal needs, responsibility, and feelings. It is contended that those conflicts stem directly from the coping styles of the alcoholic and the effect of the alcoholism on the family. Group therapy is described as a particularly beneficial therapeutic modality.

Availability: Library

Chafetz, M.E. Children of alcoholics. New York University Education Quarterly 10(3):23-29, Spring 1979.

The influence of alcoholism on children of alcoholic parents is examined. An estimated 29 million children in the United States have at least one alcoholic parent. As many as 50 percent of today's alcoholic individuals are children of alcoholics, illustrating the cycle of alcoholic parent and disturbed child. Adolescents are at a particularly susceptible age to be influenced by adult behavior. A disrupted marriage and abusive behavior in the alcoholic's home as well as problems encountered outside the home are all negative influences on the children. Various programs that deal with this problem, through either youth clinics or prevention programs, are cited.

Availability: National Clearinghouse for Alcohol Information
P.O. Box 2345
Rockville, MD 20852
(no cost, request RPO 323)

Cotton, N.S. Familial incidence of alcoholism: A review. Journal of Studies on Alcoholism 40:89-116, 1979.

This review and tabular outline of 39 studies compares the incidence of alcoholism in the families of alcoholics and of nonalcoholics and examines the relative frequency of alcoholism and mental illness in alcoholics' families. Although a large percentage of alcoholics (ranging from 47 to 82 percent of the samples reviewed) did not report parental alcoholism, alcoholics were more likely than the nonalcoholics studied to have parents, siblings, or other relatives who were alcoholics.

Availability: Rutgers Center of Alcohol Studies
P.O. Box 969
Piscataway, NJ 08854
(Library photocopy: $.10/page)

Deutsch, C. Broken Bottles, Broken Dreams: Understanding and Helping the Children of Alcoholics. New York: Columbia University, Teachers College Press, 1982.

This book reflects 6 years of experience in training youth professionals, those persons with whom the children of alcoholics have regular, natural, and relatively trustful contact. In the first part, certain assumptions and myths about alcoholism are examined. The way that children of alcoholics feel and react and the hazardous consequences of their upbringing are described. In the second part, the youth professionals' role in the helping process is discussed.

Availability: Teachers College Press
Columbia University
New York, NY 10027
($13.95 paperback; $17.95 cloth)

el-Guebaly, N., and Offord, D.R. On being the offspring of an alcoholic: An update. Alcoholism: Clinical and Experimental Research 3(2):148-156, 1979.

This article presents a summarized review of recent studies that deal with four issues: the need for more treatment resources; the vulnerability of children of alcoholic parents compared with those of parents with other psychiatric diagnoses; the potential sources of strength of the competent child of alcoholic parents; and the relative lack of controlled and prospective studies.

Availability: Library

Galanter, M., ed. Currents in Alcoholism, Vol. 6. New York: Grune & Stratton, 1979. This volume contains the following chapter on the topic "children of alcoholics":

Barnes, J.L.; Benson, C.S.; and Wilsnack, S.C. Psychosocial characteristics of women with alcoholic fathers, pp. 209-222.

Psychosocial characteristics of young women at "high risk" were investigated on the basis of their fathers' alcoholism for the development of a number of problems, including alcoholism. Subjects were college women enrolled in undergraduate classes at Indiana University. Five areas of inquiry were selected for study: (1) drinking behavior and attitudes; (2) affective disorders, especially depression; (3) sex role characteristics; (4) sexual behavior and attitudes; and (5) perceptions of self and parents. Results indicated that daughters of alcoholics not only drink more, but also tend to experience more drinking-related problems and are more likely to drink for "personal effects." Results did not support the hypothesis that daughters of alcoholic fathers differ from daughters of nonalcoholic fathers on depression and sex role orientation, and no clear evidence was found of sexual maladjustment among alcoholics' daughters. Clear evidence was found that daughters of alcoholics perceived their fathers differently than did daughters of nonalcoholics. Limitations of this study are briefly discussed.

Availability: Grune & Stratton, Inc.
c/o Academic Press
111 Fifth Avenue, 12th Floor
New York, NY 10003
($49.00)

Galanter, M., ed. Currents in Alcoholism, Vol. 7. New York: Grune & Stratton, 1980. This volume contains several chapters on the topic "children of alcoholics," including the following:

Jacob, T. An introduction to the alcoholic's family, pp. 505-513.

In this introduction, research studies on the alcoholic's family, his or her spouse, children, and family interactions are cited and briefly discussed.

Richards, T.M. Working with disturbed children of alcoholic mothers, pp. 521-527.

The feeling and fear and its consequences as revealed by three adolescents, each living with a mother who was alcoholic, is examined. In a brief discussion of fear and control, it is noted that the primary impact of each mother's drinking rendered her emotionally unavailable to the child. This lack of maternal response was related to a defect in each child's fear response mechanism that hampered his ability to protect himself from dangerous internal and external stimuli. Following a description of the treatment process, two clinical vignettes are presented that illustrate counterphobia (fearlessness) and obsession with loss of control.

Availability: Grune & Stratton, Inc.
c/o Academic Press
111 Fifth Avenue, 12th Floor
New York, NY 10003
($54.50)

Hamilton, C.J., and Collins, J.J. Role of alcohol in wife beating and child abuse: A review of the literature. In: Collins, J.J., ed. Drinking and Crime: Perspectives on the Relationships Between Alcohol Consumption and Criminal Behavior. New York: Guilford Press, 1981. pp. 253-287.

This chapter reviews available empirical evidence about the relationship between alcohol use and two specific types of family violence: wife beating and child abuse. An examination is also presented of proposed explanations for this observed empirical relationship between drinking or problem drinking and the occurrence of violence between family members. The findings of this review indicate that alcohol is more relevant to wife beating than it is to child abuse.

Availability: The Guilford Press
200 Park Avenue, South
New York, NY 10003
($22.50)

Hawley, N.P., and Brown, E.L. Use of group treatment with children of alcoholics. Social Casework 62(1):40-46, 1981.

Treatment needs of children of active alcoholics are discussed, and a model of group treatment that allows such children to develop skills for coping effectively with an alcoholic parent is presented. Professionals are encouraged to work more directly with this affected population, which needs specialized help.

Availability: Library

Heller, K.; Sher, K.J.; and Benson, C.S. Problems associated with risk overprediction in studies of offspring of alcoholics: Implications for prevention. Clinical Psychology Review 2(2):183-200, 1982.

It is noted that, although children of alcoholics are often described as being at risk for a variety of social and psychological problems, many of the studies that have drawn this conclusion contain

biases that lead to the overprediction of progeny vulnerability. Suggestions are made for obtaining more accurate data. Data on the frequency of positive adjustment outcomes and the characteristics that distinguish children likely to have achieved successful adjustment from those who have developed symptomatic behavior are conspicuously absent. It is contended that future prevention researchers could use this information to design programs to increase coping capacity and to provide environmental supports to reduce risks associated with alcoholic parentage.

Availability: Library

Jones, J.W. "Preliminary Test Manual: The Children of Alcoholics Screening Test," 1982.

Information on the development, reliability, and validity of the 30-item Children of Alcoholics Screening Test (CAST) is provided, including comments on how clinicians and researchers can best use this test.

Availability: Dr. J.W. Jones
6153 North Hamilton
Suite 2
Chicago, IL 60659
($5.00)

Kern, J.C.; Hassett, C.A.; Collipp, P.J.; Bridges, C.; Solomon, M.; and Condren, R.J. Children of alcoholics: Locus of control, mental age, and zinc level. Journal of Psychiatric Treatment and Evaluation 3(2):169-173, 1981.

Results are presented from a study designed to provide descriptive data on children of alcoholics as compared with children from nonalcoholic homes and to report differences in the areas of mental ability, locus of control, and level of zinc. Subjects were 40 volunteer children between the ages of 8 and 13 years. The 20 children of alcoholics were drawn from the Youth Education Series (YES) conducted by the Nassau County (New York) Department of Drug and Alcohol Addiction. Children of alcoholics were found to have depressed zinc levels prior to their drinking years and to be "externally" oriented on the Nowicki-Strickland locus of control scale. The boys were below the controls in mental ability. In these ways, children of alcoholics tend to mirror their adult alcoholic parent. Preventive and intervention strategies are discussed. The authors call upon the treatment community to include outreach, intervention, and treatment strategies in their ongoing activities for these high risk children.

Availability: Library

Knight, J.A. Family in the crisis of alcoholism. In: Gitlow, S.E., and Peyser, H.S., eds. Alcoholism: A Practical Treatment Guide. New York: Grune & Stratton, 1980. pp. 205-228.

The following general topics are discussed: psychodynamic causation in alcoholism; family dynamics; therapy with the family; and children and parental alcoholism.

Availability: Grune & Stratton, Inc.
c/o Academic Press
111 Fifth Avenue, 12th Floor
New York, NY 10003
($28.50)

Landesman-Dwyer, S. Relationship of children's behavior to maternal alcohol consumption. In: Abel, E.L., ed. Human Studies. Fetal Alcohol Syndrome, Vol. 2. Boca Raton, FL: CRC Press, Inc., 1982. pp. 127-148.

Research literature is reviewed in a discussion of the relationship of children's behavior to maternal alcohol consumption. Experimental and clinical studies of the immediate effects of maternal alcohol intake on the fetus and newborn are cited, and behavioral characteristics of offspring of alcoholic women are discussed. Clinical descriptions of children with the fetal alcohol syndrome (FAS) are provided, including findings from prospective studies of the effects of maternal social drinking during pregnancy on the growth, survival, and behavior of offspring. It is contended that the human evidence is too scant to provide a basis for judging the specificity of prenatal alcohol effects on behavioral development. Other factors that might contribute to behavioral characteristics of offspring are briefly discussed, as are their possible implications for future research.

Availability: CRC Press, Inc.
2000 Northwest 24th Street
Boca Raton, FL 33431
($64.00)

Moos, R.J., and Billings, A.G. Alcoholic and matched control families. Addictive Behaviors 7(2):155-163, 1982.

Children of relapsed and recovered alcoholic patients were compared with children from sociodemographically matched control families on a set of indices of emotional and physical status. The children of relapsed alcoholics showed more symptoms of emotional disturbance than did the control children. In contrast, the children of recovered alcoholics were functioning as well as the control children. Additional analyses indicated that the emotional status of children was related to the emotional, physical, and occupational functioning shown by their alcoholic parent and

nonalcoholic parent, as well as to family life stressors.

Availability: Library

Nardi, P.M. Children of alcoholics: A role theoretical perspective. The Journal of Social Psychology 115:237-245, 1981.

A review of the literature on children of alcoholics demonstrates a need for a social-psychological study assessing the processes and outcomes of growing up in an alcoholic family. The concepts of role theory as a research strategy are discussed, emphasizing the role conflict, sex role development, and role acquisition. It is believed that viewing the issue from this perspective leads to a sharper analysis of the dynamics of growing up in an alcoholic family than is currently available. It also presents a clearer perspective as to how so many children of alcoholics become alcoholics themselves, and suggests strategies for research, treatment, and prevention.

Availability: Library

National Institute on Alcohol Abuse and Alcoholism. Family violence. Alcohol Health and Research World 4(1):2-35, 1979.

This special focus issue on the topic of family violence contains several authored articles that reflect the complex interplay between family violence and alcohol abuse. Specific articles include an overview on the family violence problem in the United States; points of interest raised by research and available treatment and other resources; a discussion of common behavior problems and therapy with children of alcoholics; presentation of a model training program for alcohol counselors and child protective workers; interviews with three experts in the alcohol abuse and family violence fields; and a resource listing.

Availability: National Clearinghouse for Alcohol Information
P.O. Box 2345
Rockville, MD 20852
(no cost, request RPO 255)

Pilat, J., and Jones, J.W. "Screening Test and Treatment Program for Children in Alcoholic Families." Paper presented at the 30th Forum of the National Council on Alcoholism, Washington, DC, April 1982.

Research is cited in a discussion of alcoholic family systems and children of alcoholic parents. The 30-item Children of Alcoholics Screening Test (CAST) is described, and validation research on the CAST is reviewed. A three-phase treatment program for children of alcoholics, developed through a large family alcoholism treatment center located in Chicago, Illinois, is outlined. This program consists of an initial 4-week education and crisis intervention group (Phase I), a 12-week aftercare support group (Phase II), and participation in Alateen or pre-Alateen groups (Phase III). It is concluded that the CAST is a valid and reliable screening test, and that the three-phase treatment program is effective. A copy of the CAST is provided.

Availability: Dr. J.W. Jones
6153 North Hamilton
Suite 2
Chicago, IL 60659
($1.00)

Steinglass, P. Life history model of the alcoholic family. Family Process 19(3):211-226, 1980.

Research and clinical interest in the alcoholic family has tended to outpace the development of family-oriented conceptual models of alcoholism. A family development perspective has been almost totally absent, despite the chronic, longitudinal nature of alcoholism. A life history model is proposed that uses the concepts of the "alcoholic system," family homeostasis, and the "family alcohol phase" as its building blocks. Chronic alcoholism tends to produce distortions in the normative family life cycle. These distortions and their clinical implications are discussed, using four case histories as illustrations of the concepts proposed. The model is also examined in the light of current research findings about the alcoholic family.

Availability: Library

Swinson, R.P. Sex differences in the inheritance of alcoholism. In: Kalant, O.J., ed. Research Advances in Alcohol and Drug Problems. Alcohol and Drug Problems in Women, Vol. 5. New York: Plenum Press, 1980. pp. 233-262.

Evidence for the proposition that alcoholism is genetically determined is examined, and the relative effects of any genetic factors in the two sexes in this regard are compared. Twin, adoption, half-sibling, and genetic marker studies are cited and summarized, and the relationship between alcoholism and other psychiatric disorders is discussed. Conclusions are considered for each sex separately.

Availability: Plenum Press
Plenum Publishing Corporation
227 West 17th Street
New York, NY 10011
($55.00)

Wegscheider, S. Another Chance: Hope and Health for the Alcoholic Family. Palo Alto, CA: Science and Behavior Books, Inc., 1981.

In the first part of this book, the author discusses the roles played by various members in the chemically dependent family--the Enabler, the Hero, the Scapegoat, the Lost Child, the Mascot, and the Dependent. The second part of the book describes intervention and treatment programs that can put such families on the road to recovery.

Availability: Science and Behavior Books, Inc.
701 Welch Road
Palo Alto, CA 94306
($12.95)

Wolin, S.J.; Bennett, L.A.; Noonan, D.L.; and Teitelbaum, M.H. Disrupted family rituals: A factor in the intergenerational transmission of alcoholism. Journal of Studies on Alcohol 41(3):199-214, 1980.

Members of 25 middle-class families in which one or both parents was an alcoholic were interviewed in an attempt to study the relationship between the observance of family rituals and the occurrence of alcohol problems in offspring. The families were divided into three categories depending on the presence or absence of drinking problems in the children, the 12 families having no children with drinking problems being "nontransmitters," the 7 having at least one child who was a heavy drinker being "intermediate transmitters," and the 6 having at least one child who was an alcoholic or problem drinker being "transmitters." The criteria for levels of drinking problems were Goodwin's (Abst. No. 803, Vol. 34, J Stud Alc). A "ritual" was defined as patterned behavior to which the family attributed symbolic meaning or purpose, and the rituals studied were those associated with dinner time, evenings, holidays, weekends, vacations, and visitors to the home. When observances of rituals before the period of parents' heaviest drinking were compared with observances during the period of heaviest drinking, it was found that ritual life was unaltered in 8 families (5 nontransmitters and 3 intermediate transmitters). In 10 families (6 nontransmitters, 2 intermediate transmitters, and 2 transmitters) approximately half of the rituals were changed, and in 7 families (1 nontransmitter, 2 intermediate transmitters, and 4 transmitters) all of the rituals were changed. When the intermediate transmitters were excluded or grouped with nontransmitters, change in holiday rituals (at one time observed by 24 of the 25 families) was significantly (p less than .05) associated with the transmission of alcoholism. Nontransmitters protected family rituals (i.e., observed them during the period of the parent's heaviest drinking as they had in the past) much more (p less than .005) than the other two groups of families.

Availability: Rutgers Center of Alcohol Studies
P.O. Box 969
Piscataway, NJ 08854
(Library photocopy: $.10/page)

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For answers to specific questions, you may want to write or call:

The National Clearinghouse for Alcohol Information (NCALI)
P.O. Box 2345
Rockville, MD 20852
(301) 468-2600

NCALI is an information service of the National Institute on Alcohol Abuse and Alcoholism. It is the largest, most comprehensive resource for alcohol information in the world. NCALI's materials are free to the public. The Clearinghouse also produces Alcohol Health and Research World, a paid-subscription quarterly magazine, and Alcohol Awareness Service, a bi-monthly alcohol information service.

Other sources of information and referral to local facilities include:

Alcoholics Anonymous (AA)
P.O. Box 459
Grand Central Station
New York, NY 10163
(212) 686-1100

With more than one million members in 114 countries, AA is the largest self-help group for recovering alcoholics and problem drinkers. Local groups are listed in most telephone directories.

Al-Anon Family Group Headquarters
P.O. Box 182
Madison Square Station
New York, NY 10159
(212) 683-1771

Al-Anon Family Groups, which include Al-Anon for adults and Alateen for youth, are self-help groups for family members and friends of problem drinkers. Local groups are listed in most telephone directories.

Resources:

National Association for Children of Alcoholics (NACoA)
31706 Coast Highway
Suite 201
South Laguna, CA 92677
(714) 499-3889

Incorporated in 1982, NACoA is a national, nonprofit association for children of alcoholics in all age groups. NACoA publishes a quarterly newsletter and hosts an annual convention.

The National Council on Alcoholism, Inc.
12 West 21st Street
New York, NY 10010
(212) 206-6770

The NCA is a national voluntary health agency that provides information about alcoholism and alcohol problems through its local affiliates. Some of the NCA's affiliates provide counseling of alcoholics and their families.

Children of Alcoholics Foundation
540 Madison Avenue
23rd Floor
New York, NY 10022

The Children of Alcoholics Foundation is a voluntary, nonprofit foundation established to increase public awareness of the problems of children and young people from families with alcoholic parents. Some written materials are available at no charge.

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